

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SEMECTOR MEDICAR	RE & MEDICAID SERVICES
ENTERS FOR MEDICAL	(E. G. MILDIO)

STATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION

(x1) PROVIDER/SUPPLIER/CU IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY

COMPLETED

09G168

B. WING

A BUILDING

02/03/2007

(X5) COMPLETION

DATE

PRINTED: 02/26/2007 FORM APPROVED

OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER

ST JOHN

(X4) ID

PREFIX

TAG

(1) 2000 (2014) 3.14.6

STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-

REFERENCED TO THE APPROPRIATE DEFICIENCY)

INITIAL COMMENTS W 000

A recertification survey was conducted from January 30, 2007 through February 3, 2007. The survey was initiated using the fundamental survey process. A sample of two clients was selected from a resident population of four men with various disabilities. (In February 1, 2007, the survey was extended in the Conditions of Client Protections and Heath Care, following review of

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

(2) Client #2's medication regimen (including PRN serious cardiovascular side effects);

(3) monitoring and coordination of Client #2's treatment needs, salety and due process rights

(4) monitoring and coordination of Client #2's health care services, across disciplines. Also on February 1, 2007, Immediate Jeopardy was declared after the facility failed to demonstrate that it had ensured the safety of Client #2 at all times including weekend visits with his parents. Th∋ survey was extended to a full survey later in the day on February 1, 2007.

The findings of the survey were based on observations and staff interviews in the home and in Governing Body and Health Care Services. W 102 483,410 GOVERNING BODY AND MANAGEMENT

> The facility must ensure that specific governing body and management requirements are met.

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

W 000

PREFIX

TAG

(1) Client #2's ongoing emergency room visits with no pulse: sedation and drugs with potential for producing

with his parents; and

at one day program, interviews with one client, as well as a review of client and administrative records, including incident reports. The determination was made that the facility was not in compliance with the Conditions of Participation

TITLE

(XB) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

W 102

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

12

PRINTED: 02/26/2007 FORM APPROVED OMB NO. 0938-0391

	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	O MEDIONID SERVICES			<u>Q</u> MB	<u>NO. 0</u> 938-03 <u>9</u> 1
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	į.	ULTIPLE CONSTRUCTION LDING	(X3) DA	TE SURVEY MPLETED
, § ·		09 G168	B. WIN	IG		2/03/2007
NAME OF	PROVIDER OR SUPPLIER			CTBEET ADDDESS OF A		2/03/2007
sт Joн	N .			STREET ADDRESS, CITY, STATE, ZIP C 3012 MILITARY RD, NW WASHINGTON, DC 20015	ODE	
(X4) ID	SUMMARY STA	EMENT OF DEFICIENCIES	 _1			
PREFIX TAG	REGULATORY OR LE	MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	PREFI; TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPE	OULD BE CROS	S. COMPLETION CY) DATE
	Cross-refer to W318 Immediate Jeopardy facility failed to demo the safety of Client # weekend visits with I concerns identified v 1. The governing bo implement a system review of clients' trea include clear explana benefits of proposed Client #2's prescribin monthly psychotropic However, review of th documentation failed potential risks associ medication regimen (individual medication negative drug interact identified and explain Review of the client's evidence that the full weighed the benefits the treatment plan, in use of Chloral Hydrat visits, to ensure the c 2. The governing boo	on the met as evidenced by: On February 1, 2007, was declared after the nstrate that it had ensured at all times, including is parents. The primary were as follows: dy failed to establish and of documenting a thorough attent plan and options, to ation of potential risks and medication regimens. psychiatrist had conducted medication reviews (PMR). It monthly PMR to show evidence that the atted with the client's possible side effects from as as well as the potential for tions) had been clearly and to the client's parents. records also failed to show interdisciplinary team had and risks associated with cluding but not limited to the estedation during home I ent's health and safety. Ity failed to ensure that the	W 1	1. A treatment plan me was held on 2/23/07 the included the Director of Nursing, Director of Clahouse manager, QMR parents and the individed discuss all medications current regimen with the and benefits. The pare were provided a list of medications being administered along with risks and benefits. The signed off on the Information Consent for the Use of Medications. 2. During the treatment meeting the parents retraining on how to proping document the medication are administering to the while in the home. The will be provided MAR for sign off on the prescrib medication at the approxime. The parents reported.	t plan ceived parents on they eir child parents orms to ed opriated	2/23/07
	facility implemented a	system to document Client Iministration of medications		they understood the importance in relation to son's health.		

		& MEDICAID SERVICES		•	OMB NO	APPROV
TATEMEN'	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE 5	
		DENTI TOATION NOMBER:	A. BUILDI	NG	COMPL	
, v. V.		09G168	B. WING		1	
AME OF P	ROVIDER OR SUPPLIER	333100	<u> </u>		02/0	3/2007
ST JOHN		•	1 :	REET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015		
(X4))D	SUMMARY STA	TEMENT OF DEFICIENCIES	ID			
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL ISC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	AF CDOSS	(X5) COMPLETION DATE
W 102	Continued From pa	e 2	W 102			
		ydrate sedative had been	** 102			
. [prescribed and filled	: ол October 11, 2006.				
İ	Interviews and reco	rd review revealed that the				
	Chloral Hydrate had	not been administered in the				
< E-	facility; it was used in	luring home visits with his				
	parents. The bottle	was approximately 55% full at			i	
os militaria	the time of the surve	y. There was no		,		
	accumentation, how	ever, of the date, time or				
	amount administere	ved during the family visits.				
	medications lie rece	ved during the family visits.				
	It should be noted th	at Chloral Hydrate is a				
	Schedule 3 drug, Ti	e disposition (use/				
	administration) of the	medication was not being				
1	recorded in accorda	nce with federal law,				
;	3. The governing bo	dy failed to ensure that Client				
7	#2's medical team th	proughly investigated health		•		
6	emergencies, to incli	ide comprehensive and	Ì	The PCP and the Medica	al l	
	imely evaluations to	determine the etiology of		Team completed a thoroug	h l	
'	ainting and pulse-le:	is episodes.		evaluation of #2's medical		
. 9	Staff interviews and	eview of Client #2's medical	-	· · · · · · · · · · · · · · · · · · ·		
	chart revealed ongoing	ag trips to hospital]}	record on 2/1/2007. The	. [
^{∷/.} ¦∈	emergency rooms F	le experienced two fainting	(,	evaluation went back to 20	T T	
" e	pisodes in Septemb	er 2006. Staff interviews		A diagnosis of syncope was	S	
j ii	ndicated that the cat	se had not been determined		the result and he was		
· .	Inspection of the ho	spital discharge summaries	į,	prescribed Fludrocortisone		
ir	ndicated low blood p	ressure and dehydration;]]	E		
1	owever, the precise	cause of the low blood		The etiology of the fainting	ļ	
P	ressure was not ide	ntified.		spells is still being		,
ہ	n lanuarian anos	Client #2 was a fi		investigated, #2 saw the		
1	on January 29, 2007 The emergency rec	Client #2 was again rushed				
10	o the emergency roc onsciousness at his	ज after ne lost day program. The client		cardiologist recommended		
· [w	as described as nor	responsive and the day		event monitor for 30 days. I		
p	rogram nurse report	edly was unable to detect a	i	still has another week with		
p	ulse. Nobody in the	facility had determined		monitor and then he will foll	ow- ::	
100	hother or not the all	nt had received Chiloral		up with the cardiologist.	- ' ' '	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/26/2007 CENTERS FOR MEDICARIE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B, WING 09G168 NAME OF PROVIDER OR SUPPLIER 02/03/2007 STREET ADDRESS, CITY, STATE, ZIP CODE ST JOHN 3012 MILITARY RD, NW WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENC) MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION PREFIX (X\$) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REGULATORY OR LEC IDENTIFYING INFORMATION) PREFIX TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG W 102 Continued From page 3 W 102 Hydrate during the weekend immediately preceding the incident. The systemic effect of these practices results in -4-287 the failure of the governing body to adequately manage and govern the facility and to ensure its compliance with the condition of Health Care A. 10 (1) Services. 483,410(a)(1) GOVERNING BODY W 104 W 104 The governing body must exercise general policy. MARK budget, and operating direction over the facility. SY This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the governing body exercised operating direction over the facility except for in the following areas: The findings include: Cross-refer to W153. The governing body 1. Staff will be trained by the failed to implement an internal Quality Assurance Incident Management system to detect the following: Coordinator on the completing Facility staff failed to notify the Department of incident reports, the reporting Health of all incidents that presented a risk to the protocol and all parties that 4500 clients' health and safety. need notification. This training will include all staff and nurses b. Facility staff failed to complete an incident report after being informed by day program staff to ensure that everyone has

unknown origin.

by a staff person.

that Client #3 made an allegation of verbal abuse

c. The facility's charge nurse failed to complete incident reports upon discovery of injuries of

an understanding of the

reporting protocol.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/26/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED B. WING 09G168 NAME OF PROVIDER OR SUPPLIER 02/03/2007 STREET ADDRESS, CITY, STATE, ZIP CODE ST JOHN 3012 MILITARY RD, NW WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX REGULATORY OR LISC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-TAG TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE W 104 Continued From page 4 W 104 2. At the treatment plan The governing body failed to establish and meeting on 2/23/07 the implement a system to document that Client #2's parents of #2 was provided the parents, and other legally-authorized healthcare limited quardianship decision-makers, received all pertinent information regarding the benefits and risks of paperwork. The parents proposed treatments, including potential side provided the signed notarized effects and drug interactions. guardianship paperwork on W 111 483.410(c)(1) CLIENT RECORDS W 111 3/6/07 for #2. It has been placed in the medical and ISP The facility must develop and maintain a $/\sqrt{2}, \frac{n}{2}, \frac{1}{2}, \frac{1}{2}, \frac{1}{2}$ recordkeeping system that documents the client's book. The parents were 150 mm 100 1 mm health care, active treatment, social information, provided a list of all the and protection of the client's rights. (y/. ₩) medications being administered along with their This STANDARD is not met as evidenced by: risks and benefits. The parents Based on interview and record verification, the signed off on the Informed facility failed to maintain a record keeping system Consent for the Use of that contained all per inent client information in the active client files, for three of the four clients Medications. residing in the facility. (Clients #1, #2 and #4) The findings include: 1. #1 went to the ER on 1. Following observation of the morning medication pass on January 30, 2007, Client #1's 1/13/07 and discharged on records were reviewed. His Medication 1/15/07. The attending Administration Record (MAR) for January 2007 physician recommended that indicated that aspirin had been discontinued on aspirin be discontinued and on January 15, 2007 and another medication, 31 Aggrenox, had been started, the following day, prescribed Aggrenox 200mg. His record contained a physician order (PO). dated January 16, 2007, for the Aggrenox, The information was however, there was no PO for stopping the communicated to the PCP and aspirin. Interviews with the LPN Charge Nurse and the primary care physician later that day annotated on the Physician's confirmed that the ascirin had been discontinued. order on 1/19/07. There is a Upon review of the chart, the Charge Nurse P.O. in the medical book indicated the discontinuance.

heet Page 5 of 42

DEPA	RTMENT OF HEALTH AND HUMAN SERVICES ERS FOR MEDICARE & MEDICAID SERVICES			PRINTED	02/26/2007
STATEME	INT OF DEFICIENCIES (X1) PROVIDER/SUBBLIEBLO	_ ,		OMRNO	1 APPROVED 2. 0938-0391
AND PLAN	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE S	SURVEY
	09G168	B. WIN	G		
MAME OF	PROVIDER OR SUPPLIER			02/0	3/2007
ST JOH			STREET ADDRESS, CITY, STATE, ZIP CO 3012 MILITARY RD, NW WASHINGTON, DC 20015	ODE	
(%4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID			
PREFIX TAG	REGULATORY OR LEC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	OULD BE appear	(X5) COMPLÉTION DATE
W 111	Continued From page 5	W 11	4		<u> </u>
	confirmed that there was no PO for d/c'ing the aspirin.			,	
AAA SIII 2 SIII 2 SIII SIII SIII SIII SI	2. Review of Client #1's chart revealed that he had undergone a colonoscopy on September 7, 2006. The hospital records indicated that 3 polyps had been removed, with biopsies to be performed. Further review of the record and interviews with the LPN Charge Nurse revealed that the facility had not sought to obtain the results of the biopsies for the record. [Note: Interview with the primary care physician on January 31, 2007 revealed that he had received a letter indicating that the polyp tissues were benign.] 3. On a bi-weekly basis, the facility was releasing Client #2 to his parents for home visits. His parents administered medications during the home visits but were not documenting the date, time or amounts of any of the medications administered. The facility had not established a system for keeping the client's chart current, for medications administered outside the home. 4. The facility had not documented in Client #2's chart a full review of the risks associated with his current medication regimen and treatment plan, and potential for drug interactions, with the client's parents, who served as his designated surrogate healthcare decision-makers. 5. A nursing progress note dated July 5, 2006 indicated that "swelling" was observed in Client #2's sacral area. The client had just returned from an overnight visit with his parents. The nurse did not describe in detail what he observed on the facral area and did not report it up the chain of		2. The Director of Nursicheck with the PCP to she has the results of the biopsy or request for the results from Sibley Hosp have in the medical reconstruction. 3. During the treatment meeting the parents on 2/23/07, they received the medication they are administering to their chick while in the home. The pwill be provided MAR for all home visits to sign off the prescribed medication the appropriated time. The parents reported that the understood the important relation to their son's hear this training will be composited all the families.	plan raining ment ild varents ms for on n at ne y ce in olth.	
Print 1 2	ndicated that "swelling" was observed in Client # 2's sacral area. The client had just returned from an overnight visit with his parents. The nurse did not describe in detail what he observed on the		with all the families.		

DEPA CENT	RTMENT OF HEALTI	AND HUMAN SERVICES			PRINTED: 02/26/2007 FORM APPROVED
SIAILME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		09G168	B. W	NG	
NAME OF	PROVIDER OR SUPPLIER			CERT ARREST	02/03/2007
ST JOH	IN .			STREET ADDRESS, CITY, STATE, ZIP COD 3012 MILITARY RD, NW	DE
(X4) ID PREFIX TAG	(EMUR DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC (DENTIFYING INFORMATION)	ID PREF TAG	The second of th	ILD DE ORGER AGUSTING
· .	investigated by the policies. Further repolicies. Further represented that the prexamined him two controlled the PCP recommented the PCP recommented the PCP recommented the client went to a conjuly 26, 2006, at "no drainage noted." 43 AM, interview with revealed that he thou abscess." Moments pressure sore. He will description in the nature of the "swelling provide sufficient information what was being reserved to the provide sufficient information what was being reserved for hemorrhold the said he thought use." Hospital discharge 2006, indicated they suppositories for 7 days however, that the original ted and/or that the	OMRP, as per the facility's view of the-client's chart mary care physician (PCP) ays later, on July 7, 2006. Inded "surgery clinic 19 days later, which time the clinician wrote. On February 1, 2007, at 11: in the LPN Charge Nurse light it had "looked like an later he said it had been a as unable, however, to find a client's chart to indicate the g." Client #2's record did not rmation to ensure accuracy.	W	1 A A namplete short rout	ew 7 that ent his ared ly has to be haker welling y 5, see on t was d him hic to e
	2 days of survey. Soir Pyschotropic Medicating examined initially. How conduct the record ver hird day, the entire board While copies of docurn	al Support Plan (ISP) rved onsite during the first ne of its contents, such as on Review sheets, were vever, when it was time to ification process on the ok was deemed "missing." ents were later retrieved stituted ISP record book,		6. Anusol Suppositories at the home for as needed by for #4 hemorrhoids. 7. The original ISP book work to located on 3/7/07. It was for	asis as pund
tí	ne facility's administra	tors acknowledged that		in the van of another home	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2007 FORM APPROVED OMB NO. 0938-0391

STATE	MENT OF DEFICIENCIES	(XI) PROVIDENCES				OMB NO	<u>0938-039</u>
AND PL	AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFIÇATION NUMBER:	(X2) N	#ULT!	PLE CONSTRUCTION	(X3) DATE	
		** ***********************************	A. BUI	ILDIN	G	COMPL	LETED
		09G158	B, WIN	۷G			
NAME	OF PROVIDER OR SUPPLIER			_		02/0	03/2007
STJO	ОНИ			30	EET ADDRESS, CITY, STATE, ZIP CODE 112 MILITARY RD, NW	· ·	
(X4) I	D SUMMARY STA	TEMENT OF DEFICIENCIES		w	ASHINGTON, DC 20015		
PRÉF TAG	IN LEADED DEFICIENCY	MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE OF	DE ABAAA	(X5) COMPLETION DATE
. W 1	11 Continued From pag	ie 7	 				
i	they could not verify	with certainty that all	W 1	11			
100.00	documentation was	available for rovinus		- 1			
₩ 12 DE	4 483.420(a)(2) PROT RIGHTS	ECTION OF CLIENTS	W 12	24			
mente de la							
ر (البائلة المراجعة br>المراجعة المراجعة ال	The facility must ens	ure the rights of all clients.					
3.17 A.17	Tringletore the tacility	Must inform pack allows					
	Thateur (ii rue client is	a Minor) or legal guardian					
	i or me client 2 W60lCs	li CONDITION, developmental					
" ·	and behavioral statu	s, attendant risks of					
•	incatinent, and or the	right to refuse treatment.		ļ			
	i I		! 				i
F1 - 129						}	
, 5.	This STANDARD is	not met as evidenced by:				ļ	
	The pased our luferview Su	IC record review that leading					ļ
F7 481 *	I range to document the	It each client and/or their			/		ľ
$\bigvee\!$	i regai representative re	eceived a thorough review of	'	1	4441		, 1
	to include a clear evel	plan and alternative options,		11	. #1's psychological	İ	
	potential risks of treat	anation of the benefits] a	ssessments specifically	1	Ì
\mathcal{W}^{-1}	psychoactive drugs, and	nd the right to refuse		\$	tates "he require guidance	:	
arts.	treatment, for two of the	ne two clients in the sample.		ľw	hen making major life	\\	j
- 1	(Clients #1 and #2)	re two offerits in the sample,		i di	ecisions". It also states that	. 1	
	 _, _	'		h	e " may be able to	1	1
v , 1	The findings include:				oderstand the	j	
	1 On Ingues 20 000			"	nderstand the concept of a		1
	the recently-bired Own	7, beginning at 10:13 AM,		ı a	lurable power of attorney" if	it	
	Professional (OMPO)	ified Mental Retardation and the House Manager (IS	explained in concrete terms	s	1
	HM) were interviewed:	at the onset of the survey.		∥ th	at are relevant to his prior	1	
	They indicated that nor	18 Of the clients had court in		ex	periences and are broken	;	1
}	appointed guardians,	l ne immediate-past OMRP L		de	own into small units of		:
	and the newly-assigned	QMRP were interviewed 👃		int	formation to which he can		
	the following morning.	The past OMPD		76	ve brief verbal	-	1
,.	confirmed that none of	them had quardians		9"	ve brief verbal responses,	:	
1226	Cirent #1 Was without 3	NVOne legally-authorized to			ld if someone in his life	:	
	represent his rights. If	le past OMRP further		ар	propriate to serve in this		-
i	stated that Client #1 ha	d the capacity to process			pacity."	1	

CENT	ERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES		•	FORM): 02/26/200 (I APPROVE)
1 WINTEMI	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULT	IPLE CONSTRUCTION	OMB NO. 0938-0: (X3) DATE SURVEY COMPLETED	
		09G168	B. WING			
NAME O	PROVIDER OR SUPPLIER			TET ABBUTTA	02/0	3/2007
ST JO	HN		3	REET ADDRESS, CITY, STATE, ZIP CO 012 MILITARY RD, NW VASHINGTON, DC 20015	DDE	
(X4) ID PREFIX TAG	, I GMUN DEFIGIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OHI IN DE ODOBO	(X5) COMPLETION DATE
.,	information and cou when things are exp reportedly outlined in ISP). The new QMF psychologist thought process information attorney. On January 31, 2007 12:55 PM, review of contradictory docum capacity to process i obtain written consert procedures, as follow. - Face sheet (not date Need to be acquired. - There were several for such issues as "Comedical Consent" and all left blank and unsignature arrangements that arrangements that arrangements that arrangements that arrangements indicating "I and understand the appersons representing form. The client had a colonoscopy performers was no evidence that the serious revidence that the serious revisions representing the colonoscopy performers and evidence that the serious revisions revisio	d make informed decisions if/ lained to him. This was I the Individual Support Plan (IP concurred, saying that the The client had the capacity to and ability to sign a power of , beginning at approximately Client #1's records revealed entation as to the client's Information, and a failure to Its prior to surgical Is: ed) indicated "Guardianship: If others; however, they were gned. It for funeral/burial Inong other things, had "no The contract was signed 6/26/00. The undersigned have read Bove instructions." No other The client had signed the Ipolyps removed during a Id earlier that day. There The benefits ans risks	W 124			
	colonoscopy performe was no evidence that t associated with perform been explained to Olies	d earlier that day. There he benefits ans risks ming a colonoscopy had				

the procedure.

<u> </u>	RS FOR MEDICARE	AND HUMAN SERVICES			FORM); 02/26/2007 // APPROVED
THE STABLEMEN	NT OF DEFICI E NCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE S	
		09G16B	B, WING			
NAME OF	PROVIDER OR SUPPLIER		<u> </u>			3/2007
ST JOH	N			TREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015	:	
(X4) ID PREFIX TAG	1 (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SO IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATION	D BE OBOSS	(X5) COMPLETION DATE
W 124	Continued From page	ge 9	W 12	4		
PANÊNE	- Court documents of his commitment to statute was continued.	dated 10/13/06 indicated that services under the State MR ed.				
OSB STATE AND F. NO B.	am unable to provide decisions concerning placement or financi cognitive level. How be explained to me of	DB, included the following: "I independent/informed independent/informed in matters due to my rever, these matters should on the level that I understand include be given to my input"				·
	Indicated moderate rand moderate/severe evaluation also included guidance when makingled explanation of hithat are relevant to his broken down into smay be able to make about his residential prabilitation. However equire direction from pest interests when it about his finances, made about his finances, makingled explanation.	the can be expected to others who represent his comes to making decisions edical treatment and end-of-able to understand the				
ir to a L re	The client's record dictivaluation or timely dinterdisciplinary team or process information and/or his legal status ater in the survey, interested that Client #7 are physician had bo	not reflect further				

JENIE	RS FOR MEDICAR	H AND HUMAN SERVICES 8 MEDICAID SERVICES				FORI	D: 02/26/200 M APPROVEI
⇒©YATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) N A. BU		TIPLE CONSTRUCTION NG	(X3) DATE	
		09G168	B. Wil	۷G_			
MAME OF	PROVIDER OR SUPPLIER		<u> </u>			02/	03/2007
эт Јон	N			3	REET ADDRESS, GITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SID IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	AE COMBS.	(X5) COMPLETION DATE
W 124	Continued From pa	ge 10	10/4	_			<u> </u>
	he would benefit from medical decisions, available for review of the affidavits, whi	on having a guardian for The affidavits were not in the client's record. Review ich were submitted via fax	W1	24			i
STATE AND PE	were achieved more 06 ISP meeting; the 20/06 and the prima	7, later revealed that they e than 6 months after his 5/3/ psychologist's was dated 11/ pry care physician's was dated effe was no person or entity out the client's rights.			,		
S.T.	hospital ER on Janu staff determined that raise his right arm. event as a transient recommended a chat When interviewed or AM, the client acknown many tests. Furt revealed that to date of the results of the testaff.	ant Client #1 was taken to a any 13, 2007 after he and the could not stand up or The hospital diagnosed the ischemic attack, or TIA, and ange in his medications. In January 30, 2007, at 6:52 wiledged that the hospital had ther interview, however, he had not been informed asts, the diagnosis of TIA, or irin to Aggrenox to prevent					
Arction 1	the recently-hired Questions Manager (HM onset of the survey, acked the capacity to effectively to provide parents were actively reatment planning are son's surrogate health When asked if the pother client's medication of the formal of the potential for negative	alified Mental QMRP and the were interviewed at the They indicated that Client #2 process information informed consent. His involved in his care and were recognized as their care decision-maker. Itential risks associated with regimen (possible side in medications as well as the drug interactions) had been client's parents, they were			2. A medical and psychological affidavit had completed in the evident #1 is ever in a state where he is unable to state whether or not he wants to have a medical procedure done. The documents were usubmitted to the assigned case manager to be submitted and have a limited medical guardian appointed.	e	}

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES MEDICAID SERVICES STATEMENT OF DEFICIENCIES MEDICAID SERVICES STATEMENT OF DEFICIENCIES MEDICAID SERVICES STATEMENT OF DEFICIENCIES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MARKE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015 (X4) ID PREFIX TAG MEGULATORY OR LISC IDENTIFYING INFORMATION) MASHINGTON, DC 20015 PROVIDER'S PLAN OF CORRECTION MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) MASHINGTON, DC 20015 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- COMPLETION DATE W 124 A treatment plan meeting was held on 2/23/07 that included
A BUILDING NAME OF PROVIDER OR SUPPLIER ST JOHN STATEMENT OF DEFICIENCIES OPG168 NAME OF PROVIDER OR SUPPLIER ST JOHN STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015 PREFIX TAG REGULATORY OR LISC IDENTIFYING INFORMATION) W 124 Continued From page 11 NO 0938-039 (X2) MULTIPLE CONSTRUCTION A. BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE W 124 A treatment plan meeting was
A BUILDING O9G168 NAME OF PROVIDER OR SUPPLIER ST JOHN STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015 (X4) ID PREFIX REGULATORY OR LISC IDENTIFYING INFORMATION) TAG W 124 Continued From page 11 not sure. They also did not know whether the
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015 (X4) ID PREFIX REGULATORY OR LISC IDENTIFYING INFORMATION) TAG W 124 Continued From page 11 not sure. They also did not know whether the
NAME OF PROVIDER OR SUPPLIER ST JOHN STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015 [X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) WASHINGTON, DC 20015 D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 124 Continued From page 11 Not sure. They also did not know whether the
ST JOHN STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015 PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) WASHINGTON, DC 20015 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) OATE W 124 Continued From page 11 not sure. They also did not know whether the
ST JOHN 3012 MILITARY RD, NW WASHINGTON, DC 20015 (X4) ID PREFIX REGULATORY OR LISC IDENTIFYING INFORMATION) WASHINGTON, DC 20015 ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 124 Continued From page 11 Not sure. They also did not know whether the
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) W 124 Continued From page 11 not sure. They also did not know whether the
TAG REGULATORY OR LISC IDENTIFYING INFORMATION) W 124 Continued From page 11 not sure. They also did not know whether the
not sure. They also did not know whether the
not sure. They also did not know whether the
held on 2/22/07 that
parents had signed written consent for the current held on 2/23/07 that included
medication regimen. They did, however, indicate
that the parents attended most of his medical Director of CLS DC
2000intropate toom months = -1
To the psychiatrist's office
ine individual to discuss all
The following medications were included in Client medications on his current
#2's January 2007 physician's orders (POs): Diphenhydramine 25 mg cap (Benadryl) 1 cap at henefits. The parents was
bedtime; Docusate Sodium 100 mg cap (Colace) benefits. The parents were
1 cap daily Benztrorine MES 2 mg tab /Constrail
1) 1 tab once a day for excessive drooting: Tritental medications being
300 mg tab 1 tab twice a day for seizure
prevention; Fludroco tisone 0.1 mg tab (Florine)
1 tab daily for eczerna; Clonazepam 2 mg tab (risks and benefits. The parents
Klonopin) 1 tab 3 times a day "for symptoms signed off on the Informed
related to psychotropic dx"; Guaifenesin Syrup Consent for the Use of
240/ml (Robitussin) 2 teaspoons twice daily treatment; Guaifenesin Syrup 240/ml (Robitussin) Medications. The Chloral
2 teaspoons twice daily, as needed (PRN); Hydrate was discontinued on
Clozapine 100 mg tab (Clozaril) 2 tabs every 2/5/07.
morning, 2 tabs at noon and 3 tabs at bedtime. In
addition, there was a hand written order for
Choral Hydrate 500 mg/5 ml take 5 ml at bedtime
is needed for sleep. In addition to the
medications, the clients plan included one-on-
one staff supervision, 16 hours daily, for behavior intervention and safety.
along with the risks and the
Client #2's prescribing psychiatrist had conducted benefits. #2 continues to
monthly psychotropic medication reviews (PMR)
However, review of the monthly PMR
documentation failed to show evidence that the
potential risks associated with the client's safety. The Director of Nursing
medication regimen (possible side effects from individual medication regim
nicividual medications as well as the potential for asked that documentation be
identified and explained to the client's parents.
medication regimen along with

review.

/ A LEMIE	VI OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	<u> </u>		PORM OMB NO	1 APPROV 0. 0938-03
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CONSTRUCTION LDING	(X3) DATE S	SURVEY
		09G168	B. WIN	G	1	
AME OF	PROVIDER OR SUPPLIER	1	,		02/0	3/2007
эт ЈОН∣				STREET ADDRESS, CITY, STATE, ZIP CO 3012 MILITARY RD, NW	DE	<u> </u>
(3(4) 10	SUMMARY STA	"EMENT OF DEFICIENCIES	 -L	WASHINGTON, DC 20015		
PREFIX TAG	I I I CONTRACTOR OF THE PROOF	MUST BE PRECEDED BY FULL CONTROL INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	HILD DE GRADA	(X5) COMPLETO DATE
N 124	Continued From pag	ie 12	1000			
-value.	Review of the client' evidence that the ful weighed the benefits the treatment plan, it use of Chloral Hydra visits, to ensure the Additional interviews QMRP and other facevidence that the particular evidence that the particular and other facevidence that the particular and the facevidence that the particular and the facevidence that the facevidence that the full particular and the facevidence that the full particular and the facevidence that the full particular and the full particular a	is records also failed to show interdisciplinary team had and risks associated with including but not limited to the ite sedation during home with the immediate-past with the immediate-past illity staff revealed no rents had been fully informed associated with their son's	W 12	24		
128 4	Client #2's parents he for the use of the afoincluding medications addition, review of the Committee minutes for evious 12 months soubject of medication interactions or obtaining lient #2's parents for even addressed. [See	ng written consent from	W 128			
fr Fe	nerefore, the facility ree from unnecessar,	rided active treatment to	,			
fa Ci	ased on staff interviet cility failed to ensure hloral Hydrate, PRN.	ot met as evidenced by; w and record review, the that the use of sedatives (during weekend visits with ncorporated into Client #2				

TATEME	NT OF DESIGNATION	H AND HUMAN SERVICES		· · · · · · · · · · · · · · · · · · ·	FOR	ED: 02/26/2 RM APPROV
ND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE	O. 0938-0 SURVEY PLETED
·		09G168	B. WIN	3_		
iame of	PROVIDER OR SUPPLIER				02	/03/2007
ST JOH	- <u></u> -			STREET ADDRESS, CITY, STATE, ZIP COD 3012 MILITARY RD, NW WASHINGTON, DC 20015	E	,
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR		(XS) COMPLETIC DATE
W 128	Continued From pa	ge 13	<u> </u>			
	's Individual Prograi Support Plan (BSP)	n Plan (IPD) and nate :	W 12	8		
l	The findings include	; ·				
1	parents administere: home visits but were	asis, the facility was releasing nts for home visits. His medications during the not documenting the date, by of the medications		The parents are no long administering medications	ger 2/	23/07
	A bottle of Chloral Hy prescribed and filled of request of the parents Charge Nurse and the ndicated that the client every evening and did in the facility. The Childring the home visits	drate sedative had been on October 11, 2006, at the s. Interviews with the LPN e RN Nursing Director both not received 25 mg Benadryl not have trouble sleeping loral Hydrate was used only with his parents. The ely 55% full at the time of		without the MAR forms. T parents were trained on h properly document the medication administered a will turn in the Mar's to the home after the visit. The Choral Hydrate was discontinued on 2/5/07.	ow to	(minimushan aja) (**) Vele u i
p: no as	p evidence that the plants sleep. The BSP was	review of Client #2's (BSP), dated 7/10/06, and on, dated 5/2/06, showed ent had difficulty falling not revised to reflect the lition of the Chloral Hydrate		2. The Psychiatrist, psychologist, pharmacist, a PCP were all in concurrence that the Choral Hydrate was not needed. The Director of DC-CLS, QMRP, house	s ·	
aft Th the det	e client was describe day program nurse t tect a pulse. Nobody termined whether crie	ess at his day program, d as non-responsive and		manager, and parents met to discuss the current regiment and they have been informed of the risks and benefits of a medications administered. They also signed an informed consent acknowledgement orm.	ed Ill	

CENT	ERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 02/26/200 FORM APPROVE		
STALEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	ULTIPLE CONSTRUCTION	OMB NC (X3) DATE S COMPL) <u>. 0938-039</u> Survey	
		09G168	B. WIN	G			
MAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	02/0	3/2007	
S.L 10I	-IN			3012 MILITARY RD, NW WASHINGTON, DC 20015	i ÇE		
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	III D DE COAAA	(XS) COMPLETION DATE	
W 128	preceding the incide 2. Client #2's routing included Klonopin. C	nt. 3, daily medication regimen 4ozaril Cogentin Repadryl	W 12	28			
ST (200 FR)	psychiatrist had con- medication reviews (PMR documentation the potential risks as medication regimen individual medication negative drug interac- identified and explair Review of the client's evidence that the full weighed the benefits the treatment plan, in use of Chloral Hydrat visits, to ensure the c	gh the prescribing fucted monthly psychotropic PMR), review of the monthly failed to show evidence that sociated with the client's possible side effects from s as well as the potential for tions) had been clearly ed to the client's parents, records also failed to show interdisciplinary team had and risks associated with cluding but not limited to the e sedation during home lient's health and safety.	W 149				
,; ,	policies and procedur	elop and implement written es that prohibit or abuse of the client.					
	failed to consistently in procedures to protect	ot met as evidenced by: d record review, the facility nplement policies and the health, safety and nts residing in the facility.					
- 300 - 100 - 100	The findings include:		,	. The Incident Managemer	nt 3/31/0	7	
	 Cross-refer to W15 failed to implement its investigating incidents 	3 and W154. The facility policies on reporting and	t	Coordinator/QA will provide raining to all staff and nurs on incidents and incident reporting.	,		

.... DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/26/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 09G168 NAME OF PROVIDER OR SUPPLIER 02/03/2007 STREET ADDRESS, CITY, STATE, ZIP CODE ST JOHN 3012 MILITARY RD, NW WASHINGTON, DC 20015 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE W 149 Continued From page 15 W 149 Interview with the facility's Incident Management Coordinator (IMC) on 1/31/07 revealed that their agency requires that the home prepare an incident report regardless of where the incident takes place (day program, for example). Staff who witness or first learn of an incident must prepare an incident report during the same shift, The report gets forwarded to the Qualified Mental Retardation Professional (QMRP) via the House Manager. The QMR is then responsible for sending a copy of the incident report to her, and to notify the DOH. The survey revealed that out of 13 incidents that presented a risk to clients' health or safety, only 1 incident was reported to the State agency/DO H. During the 1/31/07 interview with the facility's IMC, at 4:26 PM, she indicated that Client #3 made an allegation of verbal abuse on 3/23/06. The client told staff at his day program that he was verbally abused by a staff person in his home . Further interviews with the IMC and the then-2. The Human Rights QMRP revealed that although the QMRP was committee meets quarterly to made aware of the allegation the same day, he review BSP plans and the did not report it after talking with day program staff and the client. The IMC stated that she first administration of psychotropic learned of the incident in October 2006, after an medications. The outside office asked her about the incident. The guardian/family members are IMC, however, also failed to report the allegation provided consents forms to to DOH upon receiving the (late) information. complete indicating whether 2. The facility failed to implement its Human they agree or disagree with the Rights Committee policy to ensure Client #2 had BSP developed and/or informed consent prior to the use of a behavior medications prescribed. The support plan that incorporates intrusive/restrictive strategies, such as psychotropic medications and Human Rights committee оле-on-one staff supe vision. [See W124 and W meeting is also involved in the 2631 one-on-one services for

STATEM	ENT OF DEFICIENCIES	AND HUMAN SERVICES & MEDICAID SERVICES	· ·		FORI	D: 02/26/20 M APPROVE D: 0938-03:
AND PLA	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
· ·		09G168	B. WING_			
ST JOI	PROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP COD	02/0	03/2007
(X4) ID			1 3	8012 MILITARY RD, NW NASHINGTON, DC 20015	• • •	
PRÉFIX TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIA	D & &	(X5) COMPLETION DATE
.W 149	ha	ge 16	W 149	individuals.		
W 153	of all controlled drug the two clients in the 365 and W386] 483.420(d)(2) STAF CLIENTS The facility must ens mistreatment, negler injuries of unknown	ure that all allegations of to abuse, as well as	W 153	3. All controlled drugs a locked under double lo The medication is coun before administration to ensure remaining is columnth the record. Only the nurses and TME's administration to the second the second that the record.	cks. Ited oncurrent	
	established procedure this STANDARD is Based on interview a facility failed to docur abuse and/or injuries reported to the design governmental agencies.	not met as evidenced by: nd record verification, the nent that all allegations of of unknown origin were	t	medication. The Incident Managemer Coordinator/QA will provide raining to all staff and number incidents and incident eporting as required by Descriptions.	e ses	1/07
e r E fi	State agency, DOH> State agency, DOH> vent which substantiatesident's health, welfaceing or in any other wisk by telephone irruptowed up by written in the next work day." otification of one incide	are, living arrangement, well ay places the resident at nediately and shall be notification within 24 hours	¦ re	egulation (22 DC Chapter Section 3519.10).	35	

DEP CEN	ARTMENT OF HEALT ITERS FOR MEDICARI	AND HUMAN SERVICES				PRINTEL): 02/26/2007 1 APPROVED
1つ(ハ)種の	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		VIULTIF	PLE CONSTRUCTION	OMB NO	. 0938-0391 SURVEY
NAME		09G168	B. WI	NG			•
STJC	OF PROVIDER OR SUPPLIER			30	EET ADDRESS, CITY, STATE, ZIP CODE	02/0	3/2007
(X4) I PREF TAG	IX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC (DENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFÉRENCED TO THE APPROPRIATE DI	IE CEOCO	(X5) COMPLETION DATE
W 18	On January 30, 200 5:27 PM, review of the followed by interview Retardation Profess the facility failed to a following incidents in designated administ. 1. An incident report that staff observed on swelling on the left coincident report further face" and "Emergency Staff notified the Houwas no documentation administrator was producing the progress not hospital ER on 10/20, abscess." No addition available and the ER an incident report, in applicies. In addition, the following the face of the f	in beginning at approximately the facility's incident reports, is with the Qualified Mental ional (QMRP), revealed that occument having reported the immediately to their rator and to the DOH: I dated 10/18/06 indicated in Client #2 "a scratch and neek" at 6:00 AM. The indicated a "cut" on the " y Inpatient Hospitalization." se Manager; however, there in available to verify that the imptly notified. Client #2's indicated that he went to a 06 for a "mandibular"	W 1	53			
	2. A nursing progress that "swelling" was ob area. The client had jovernight visit with his describe in detail what sacral area. There we incident report was prediscovery of this injury. 3. During a 1/31/07 in the facility's Incident MIMC), at 4:26 PM, she made an allegation of	inote dated 7/5/06 indicated served in Client #2's sacral ust returned from an parents. The nurse did not had been observed on the is no evidence that an apared following the of unknown origin. The review in the facility with an agement Coordinator (indicated that Client #3 rerbal abuse on 3/23/06, his day program that a staff					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/26/2007 FINA CASSENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 09G168 B. WING NAME OF PROVIDER OR SUPPLIER 02/03/2007 STREET ADDRESS, CITY, STATE, ZIP CODE ST JOHN 3012 MILITARY RD, NW WASHINGTON, DC 20015 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR I.SC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-TAG PREFIX (X5) COMPLETION DATE REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG Continued From page 18 W 153 W 153 cursed at him. Further interviews with the IMC and the then-QMRP revealed that the incident had been reported by the day program but not by the residence. The QMRP was called on the day that the client made the allegation and he BM CM∭ reportedly went to the day program to discuss it. 372 The QMRP said he had not viewed this as an " 1,517 incident" because the client admitted having fabricated the story and recanted. The facility failed to notify their MC or the designated administrator at the time. The IMC stated that she first learned of the incident in October 2006. after an outside office asked her about the incident. The allegation of abuse was not reported to the DOH prior to this survey. W 154 483.420(d)(3) STAF TREATMENT OF W 154 CLIENTS The Incident Management The facility must have evidence that all alleged Coordinator/QA will provide violations are thoroughly investigated. training to all staff and nurses on incidents and incident This STANDARD is not met as evidenced by: reporting as required by DC Based on interview and record review, the facility regulation (22 DC Chapter 35 failed to ensure all injuries were thoroughly investigated, for one of the two clients in the Section 3519 10). sample (Client #2). The Director of Nursing will The findings include: ensure that all charge nurses 1. An incident report dated 10/18/06 indicated that receive the necessary training staff observed on Client #2 "a scratch and following orientation. This swelling on the left cheek" at 6:00 AM. The incident report further indicated a "cut" on the " includes detailed face" and "Emergency Inpatient Hospitalization." documentation of all Staff notified the House Manager. There was no treatments, observations, and evidence, however, that the incident was reported concerns noted. up the chain of command or that the injury was further investigated,

	NT OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE	
		, and the second second	A. BUILDII	NG	COMPL	
		09G168	B. WING _			
	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	02/0	03/2007
HOL TE	·		3	BO12 MILITARY RD, NW WASHINGTON, DC 20015		
(X4) ID PREFIX	: LEMON DEFICIENC	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	םו	PROVIDER'S PLAN OF CORRE	OTION.	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL) REFERENCED TO THE APPROPRIATE		(X5) COMPLET
W 154	Continued From pa	ge 19	W 154			
	2. A nursing progra	JES Boto defeat 7/5/50 :				
	mor swelling MSS	ess note dated 7/5/06 indicated observed in Client #2's sacral				
الثقال	area. The chentual	I lust returned from an				
	Overright visit with i	nis parents. The nurse did not nat he observed on the sacral			J	
500 500	erea and old liot let	1900 the chain of				
	command; therefore	the injury was not further	j			
l i	investigated by the i	QMRP, as per the facility's				
	policies.	w of the client's chart				
1	revealed that the pri-	Many care physician /popy				
	evanninga ultu MO (ii	avs later on 7/7/04 The				
	r or recommended.	"Surgery clinic IND " The				
	26/06, at which fime	ery clinic 19 days later, on 7/ the clinician wrote "no	1			
` 6	aramage noted." No available,]	additional information was				
V 159 ∠ F	183.430(a) QUALIFI RETARDATION PRI	ED MENTAL PRESSIONAL	W 159		a	
E	ach client's active to	eatment program must be	r.	The day programs are	3/9/	07
$t^{\nu \gamma}$. III	itegrateo, coordinate	20 and monitored by a	-	formed of ER visits, medic	al J	~,
Ne ∤q	ualified mental retain	dation professional,	a	ppointments, and	- 1	
Y			n	ospitalizations. They are als	so	
T. T	his STANDARD is n	ot met as evidenced by:	, ₽ .	orided doctor release cline		,
	ased on opservation	Staff and client interviews	Q	iru priysician orders with		
41	id record review, the	tacility's Qualified Montal	l Cr	nanges, if needed. This is	;	:
(1)	craidation Professio	nal (QMRP), failed to egrate and coordinate	J. us	sually done by the house		
C	ents active treatmen	It and health services for			·	4
i fAn	o or rue two clients if	n the sample. (Clients #1	j		'	
ar	ıd #2).					
Th	e findings include:	·				
1. da	The QMRP failed to y program was inforr	ensure that Client #1's ned of a significant change	}			
	2-99) Previous Versions Obsc		Facility 15	2.000.00		
			raciity IL	D: 09G168 If continuation	on sheet Page	20 of 42

DEP	ARTMENT OF HEALT	H AND HUMAN SERVICES			PRINTE	D: 02/26/200
	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION	FORM APPROV OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
		09G168	B. WING			
NAME	OF PROVIDER OR SUPPLIER		-		02/(03/2007
STJC)HN		s	TREET ADDRESS, CITY, STATE, ZIP COD 3012 MILITARY RD, NW	Ē	
(X4) II	D SUMMARY STA	TEMENT OF DEFICIENCIES		WASHINGTON, DC 20015		
PREFI TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	# * :	(XS) COMPLETION DATE
W 15	69 Continued From page	1e 20				<u> </u>
	in his health status	and new medication orders.	W 159		•	
OTA AND	had been taken to a approximately 3 weed described as being to his right arm. At 6:5 confirmed that he had he said they had run however to date, he findings. At approximation with the House Manaprimary care physicis findings, a transient in had added a new me cap, 1 cap twice daily, effective January 16, House Manager said day) had been discort there was no order shifted client's chart. Relater that day also contaken to the ER on Said	2007. [Note: While the the client's aspirin (one a tinued on the same date, lowing it had been d/c'd in view of an incident report of irmed that he had been sturday, January 13, 2007.		manager and followed — the QMRP to provide additional information and address any concerns the may have. The previous QMRP informed the day programs in December of 2006 that a new QMRP whose taking over the home, new QMRP has been to a day programs for the individuals in the home and the last visit was in Februar 2007.	d ey ould The ill the	
	PM. Interviews with the Nurse/Health Manager previously unaware the that month or that his changed. They reported having received a teles on Tuesday, January client would be out that appointments. They be were previously unaway.	ad (and had documented) chone call from the home 6, 2007 indicating the chay for "multiple medical" oth repeatedly said they re that he had been to the or that his medications				

CENT	ERS FOR MEDICAR	H AND HUMAN SERVICES			F	ORM	: 02/26/2007 APPROVED
- SIATEME	ENT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	JLTIPLE CONSTRUCTION DING	(X3) D		. 0938-0391 URVEY TED
		09G168	B. WIN	3			
MAME OF	PROVIDER OR SUPPLIER		- 			02/0	3/2007
ST JOI	in .			STREET ADDRESS, CITY, STATE, ZIP CO 3012 MILITARY RD, NW WASHINGTON, DC 20015)DE	_	
(X4) ID PREFIX TAG	REGULATORY OR I.	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COL	THE B BE ASA.	SS- ICY)	(X5) COMPLETION DATE
NAA D	orders (POs) on rest 2007. Further interpreviously unaware assigned in Client # that the client was no instead of aspirin. Back in the facility, the said they thought the notified of the ER visit documentation was substantiate their actions as substantiate their actions as informed decise however, indicated in client could process a explained in simple to the tendiscussing the "concern the QMRP failed to exinstruction from Client regarding the client's cinformation, make information, make information, make information, make information.	the most recent physician's ord were dated September liews revealed that they were that a new QMRP had been it's home and did not know ow prescribed Aggrenox The QMRP and Charge Nurse at the day program had been it and the TIA; however, no made available for review to count. 24.1. Client #1's ISP, dated the client was unable to ions. The psychologist, a 5/2/06 evaluation that the come information when information when it may be able to" when pt of power of attorney" Ilicit timely guidance and the capacity to process	W 15		nad nt #1 is e is or not dical mitted anager /e a		707
PARACO	client's mental capacition of the comment of the co	y and guardianship needs, is were protected. Densure that Client #2's flect the addition of a new on. The most recent BSP one being implemented by Review of the client's dig that Chloral Hydrate (see) had been added to his		3. A current BSP for #2 h been obtained and filed in record that reflects the curredication regimen for thindividual. The chloral hywas discontinued on 2/5/0 and the physician's orders reflect the discontinuance medication.	the rrent : e drate		

CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED B. WING 09G168 NAME OF PROVIDER OR SUPPLIER 02/03/2007 STREET ADDRESS, CITY, STATE, ZIP CODE MHOL TE 3012 MILITARY RD, NW WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-(X5) COMPLETION DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) W 159 Continued From page 22 W 159 4. The QMRP failed to ensure that Client #2's record included evidence of an interdisciplinary 2/23/07 team (IDT) review or potential side effects 4. A treatment plan meeting associated with his medication regimen, and was held on 2/23/07 that analysis of sign/symptoms of possible side effects included the Director of that the client might be currently exhibiting. Nursing, Director of CLS-DC, On January 31, 2007, at approximately 8:22 AM, house manager, QMRP, the immediate-past QMRP was asked whether parents and the individual to Client #2 was exhibiting any signs/symptoms of side effects. He replied "Not to my knowledge... NAME discuss all medications on his no known adverse side effects at this time." The ST. QMRP said his white blood cell count was being current regimen with the risks monitored closely. He said the client burned and benefits. The parents 10-3 excessive calories by remaining in constant were provided a list of all the motion, "like an Olympic marathon runner." medications being Throughout the survey, Client #2 was observed to continuously fidget with his pants, belt and socks. administered along with their He stayed in constant motion and appeared risks and benefits. The parents restless. Staff described him as agitated at times, signed off on the Informed and in constant motion, which was also documented in the record. The client was Consent for the Use of prescribed Cogentin for excessive drooling. In Medications. September 2006, he experienced two episodes of 2/23/07 fainting with low blood pressure and denydration. 5. At the treatment plan He became unconscious without a pulse on meeting on 2/23/07 the January 29, 2007. The client's chart did not include a listing of known side effects of his parents of #2 was provided the prescribed medications (which included Klonopin, limited guardianship Clozarii, Cogentin, Benadryl, Trileptal as well as paperwork. The parents Chloral Hydrate PRN). In addition, the QMRP 4.0 failed to recognize that the aforementioned list of provided the signed notarized medications had potential to cause drooling, guardianship paperwork on restlessness, loss of appetite, inability to control 3/6/07 for #2. It has been movements and mood swings. placed in the medical and ISP The QMRP failed to show evidence that Client book. The parents were #2's parents, who served as his designated provided a list of all the surrogate health care decision-makers, had medications being RM CMS-2567(02-99) Prévious Versions Obtalete administered along with their Event ID: P9G811 risks and benefits. The parents signed off on the Informed Consent for the Use of Medications.

PRINTED: 02/26/2007

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/26/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER, (X3) DATE SURVEY A. BUILDING COMPLETED B, WING 09G168 02/03/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ST JOHN 3012 MILITARY RD, NW WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID 유명EFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENC') MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG REFERENCED TO THE APPROPRIATE DEFIC 2/23/07 W 159 Continued From page 23 W 1591 received a full review of the risks associated with 6. A treatment plan meeting his medication regimen and treatment plan, and was held on 2/23/07 that potential drug interactions. included the Director of The QMRP failed to document an Nursing, Director of CLS-DC. interdisciplinary team discussion of weighing the house manager, QMRP. benefits and risks associated with Client #2's parents and the individual to treatment plan. discuss all medications on his 7. Cross-refer to W153 and W154. The QMRP current regimen with the risks failed to implement the facility's incident 50 and benefits. The parents management policies, to include reporting were provided a list of all the SFT allegations of abuse and injuries of unknown medications being origin. According to interviews and review of the facility's policies, the QMRP was responsible for administered along with their reporting incidents to outside entities, including risks and benefits. The parents the Department of Health. The survey revealed signed off on the Informed 10 incidents from the past 12 months that were not reported outside of the agency. In addition, Consent for the Use of the QMRP failed to complete an incident report following a client's allegation that staff had Medications. The minutes. verbally used him. Several injuries of unknown agenda, and the attendees are origin were not investigated, due in part to the failure to ensure that incident reports were in the client's record. 3/31/07 prepared and sent up the chain of commend, in accordance with policies. 7. The Incident Management 483.440(f)(3)(ii) PROGRAM MONITORING & W 263 W 263 Coordinator/QA will provide CHANGE training to all staff and nurses The committee should insure that these programs on incidents and incident are conducted only with the written informed reporting as required by DC consent of the client, parents (if the client is a regulation (22 DC Chapter 35 minor) or legal guardian. Section 3519,10).

This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's specially-constituted committee (Human Rights Committee, HRC)

77

DEPA CENT	RTMENT OF HEALTH ERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES		·	F	ITED: 02/26/2007 ORM APPROVED
STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	MULTIPLE CONSTRUCTION	(X3) D/	NO. 0938-0391 ATE SURVEY OMPLETED
		09G168	B. WI	NG		
NAME OF	PROVIDER OR SUPPLIER		. <u> </u>	STREET ADDRESS, CITY, STATE, ZIP C 3012 MILITARY RD, NW WASHINGTON, DC 20015		02/03/2007
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CO	IOUID BE CRO	(X5) SS- COMPLETION ICY) DATE
VV 26:	failed to ensure that used only with writter clients in the sample. The findings include Cross-refer to W124 2007 observation of administration, Client mg and Clozapine 20 House Manager/TMI record verification remedications were probehavior support plat assigned one-on-one during awake hours it safety. There was not for the aforementione program. Review of minutes for the past evidence that the convente of the past evidence that the HR how to ensure that with the convente of the use of results and super safeguards and super safeguards and super safety, welfare and circlients are adequately	restrictive programs were a consents, for one of the two (Client #2) During the January 30, the medication #2 received Clonazepam 2 for mg. Interview with the and LPN Charge Nurse and realed that these escribed in conjunction with a fin (BSP). The client was also a supervision for 16 hours for behavior intervention and evidence of written consent and behavior intervention. Human Rights Committee 2 months revealed no find the man and the facility on the intervention of the facility on the facility on the facility on the facility of the facility of the facility strategies. OF INAPPROPRIATE	j	Written consent for the and one-on-one service behavioral intervention safety has been obtain the parents of #2. The PCP and the Medited Team completed a thore evaluation of #2's medical record on 2/1/2007. The evaluation went back to A diagnosis of syncope the result and he was	cal ough cal e 2004. was one for of the ng ed an es. He ith the	2/23/07
· •	Based on staff intervie	ot met as evidenced by: w and record review, the sufficient safeguards to		up with the cardiologist.	TOIIOW-	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/26/2007 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B WING 09G168 02/03/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW ST JOHN WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY WUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) "AG REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE W 285 Continued From page 25 W 285 A treatment plan meeting was 2/23/07 ensure the safety and welfare of one of the two held on 2/23/07 that included clients in the sample. (Client #2) the Director of Nursing. Director of CLS-DC, house The findings include:

Cross-refer to W318.A. Immediate Jeopardy was called on Thursday, February 1, 2007. The facility was not able to demonstrate that it had ensured Client #2's safety at all times, including weekend visits with his parents. His parents administered medications during the home visits but were not documenting the date, time or amounts of any of the medications administered. The client returned to the facility with some pills or capsules remaining in the containers. The client's record and interviews failed to show documented evidence that the team had considered whether or not his pulse-less episodes were caused by his medication regimen. His medication regimen included routine daily Klonopin, Clozaril, Cogentin, Benadryl, Trileptal as well as Chloral Hydrate PRN (at his parents' home). Chloral Hydrate was prescribed in October 2006 as a sleep aid during his home visits. The facility had no documented evidence that Client #2's parents, who served as his designated surrogate healthcare decision-makers, had received a full review of the risks associated with the medications and treatment plan, and potential for drug interactions. The facility failed to document an interdisciplinary team discussion of weighing the benefits versus risks of the treatment plan.

In general, the facility deferred decision-making to

establishment of safeguards. There was potential for negative drug interactions between the Chloral

Hydrate, Clozarii and Cogentin (among the others

). The facility failed to determine the cause of the

the parents, without evidence of oversight and

manager, QMRP, parents and the individual to discuss all medications on his current

regimen with the risks and benefits. The parents were provided a list of all the medications being administered along with their risks and benefits. The parents signed off on the Informed Consent for the Use of Medications

The parents have completed and signed the limited medical quardian paperwork. The forms were notarized and have been placed in #2's medical and ISP book.

3/6/07

The choral hydrate was discontinued and the parents have been trained on documenting the medication on the MAR form. They were informed that this form needs to be completed with every

2/5/07

2/23/07

Facili home visit and returned to the home when the visit is completed.

IRM CMS-2567(02-99) Previous Versions Or solete

Event ID: P9G811

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2007 FORM APPROVED

STATEM	ENT OF DEFICIENCIES	WILLIAM SERVICES			OMB NO	<u>0. 0938-039</u>
AND PU	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	MULTIPLE CONSTRUCTION	(X3) DATE	
	_	09G168	B. WI	NG		
NAMEC	F PROVIDER OR SUPPLIER		_		02/	03/2007
ST JO				STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015	€	**************************************
(X4) JC	SUMMARY STA	"EMENT OF DEFICIENCIES	I ID			
PREFI TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREF TAG	TELEVISION SHOULD AND MONOR SHOULD	ID DE ABORG	(X5) COMPLETION DATE
ੁ W 28	== mineral rom pa		W	285		
D::	and whether the Ch the client at risk, inc pressure events and	(prior to the 1/29/07 episode) brail Hydrate PRN might place luding acute low blood	•			
TVY 31	Drugs used for conti must be approved by	USAGE of inappropriate behavior the interdisciplinary team.	W 3	The IDT team were aware Benadryl was being used sleep aid for #2. The IDT team opposed the use of	a	/07
en en en en en en en en en en en en en e	Based on staff intervial facility failed to provides as a sleep aid were a interdisciplinary team conjunction with an a	and were used in		chloral hydrate (as a sleep and made their concerns known to the prescribing physician.		707
y d	one of the two clients The finding includes:	in the sample. (Client #2)		The choral hydrate was discontinued and the parer were informed that the	2/5/ nts	/07
	medication regimen i Kionopin, Clozaril, Co as well as Chloral Hydra home). Chloral Hydra October 2006 as a sia	gentin, Benadryl, Trileptal drate PRN (at his parents' ate was prescribed in eep aid during his home		medication would no longe used. A treatment plan meeting was held on 2/23/ that included the Director of	07 2/2: of	3/07
W 318	interdisciplinary team benefits versus risks addition, the facility hat that Client #2's parent designated surrogate makers, had received associated with the mplan, and potential for 483.460 HEALTH CAI	discussion of weighing the of the treatment plan. In add no documented evidence s, who served as his health care decisionatelli review of the risks dications and treatment drug interactions.	W 31	Nursing, Director of CLS-Do house manager, QMRP, parents and the individual to discuss all medications on hourent regimen with the risk and benefits. The parents were provided a list of all the medications being administered along with their risks and benefits. The parents	nis (S	
N CM 5-25	87(02-99) Previous Versions Ob	plete Event ID: P9G811	Ė	signed off on the Informed Consent for the Use of Medications.		age 27 of 42

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/26/2007 AN CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING. 09G168 02/03/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW ST JOHN WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WUST BE PRÉCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG W 318 Continued From page 27 W 318 services requirements are met. WV 23 1. The parents are no longer administering medications This CONDITION is not met as evidenced by: Based on observation, interviews, and record without the MAR forms. The review, the facility failed to establish systems to parents were trained on how to provide health care monitoring and identify properly document the services that would ensure nursing services were provided in accordance with clients needs [See W medication administered and 331); failed to ensure an individual medication will turn in the Mar's to the record was maintained for one client [See W365]; home after the visit. The failed to ensure that clients received medications in medications are pre packed for accordance with physician's orders and without the duration that the individual error [See W3368 and W369]; failed to periodically reconcile a schedule 3 drug [See W will be out the home. The 386]; and failed to remove from use outdated parents were informed that all drugs [See W390]. medication provided to them is needed by the individual and should be administered accordingly. The treatment Immediate Jeopardy was called on Thursday. February 1, 2007. The facility was not able to plan meeting was held on demonstrate that it had ensured Client #2's safety 2/23/07 that included the at all times, including weekend visits with his Director of Nursing, Director of parents. CLS-DC, house manager. QMRP, parents and the On a bi-weekly basis, the facility was releasing. Client #2 to his parents for home visits. His individual to discuss all parents administered medications during the medications on his current home visits but were not documenting the date, regimen with the risks and time or amounts of any of the medications administered. The client returned to the facility benefits. The parents were

₹ vf. 1

containers.

with some pills or capsules remaining in the

2. Client #2 was rushed to an emergency room on January 29, 2007. He returned from a home

provided a list of all the

administered along with their

risks and benefits. The parents

medications being

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB N	<u>10. 0938-0</u>
TATEMEN ND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	TION (X3) DATE SUP COMPLET	
	·	09G168	B. WING _		0.0	2/03/2007
AME OF F	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CO		10312001
HOL TE	1		3	3012 MILITARY RD, NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENC"	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUILL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS	(X5) COMPLET DATE
W 318	Continued From pa	ne 28	10/ 249			
	visit that morning a while at day program happened twice in the according to staff, in cause of these heal record and interview evidence that the term or not these episodismedication regimen included routine dai Cogentin, Benadryl, Hydrate PRN (at his 3. Client #2 had be however, the Chlora October 2006. Nobihow much Chloral H	nd collapsed later that day in, with no pulse. This had beptember 2006 and obody had determined the th emergencies. The client's is failed to show documented am had considered whether es were caused by the . His medication regimen y Klonopin, Clozaril, Trileptal as well as Chloral	W 318	signed off on the Information Consent for the Use of Medications. 2. #2 has a diagnosis of syncope and is current receiving adequate treather is also seeing a cardiologist who current him on an event monitor if the fainting spells are to his heart condition (no valve prolapsed and pulmonary outflow murrowill follow-up with the	of ly atment. tly has or to see related nitral	
	medical literature sube performed appro- along with blood wor most recent ECG was 4. The facility had no Client #2's parents, sourrogate healthcare received a full review	ggests that an ECG should kimately every 3 months (k), the Charge Nurse said his as performed in 2003. I documented evidence that who served as his designated decision-makers, had of the risks associated with treatment plan, and potential		cardiologist when the monitoring is complete. 3. The physicians are tale another approach with # because the ECG required individual to sit still for 4 minutes. In #2's case the be impossible.	es an	
r c p n n b	evealed that he rout prescribing psychiatr of the client's psycho primary care physicial nedications might be nanifestations, if the ne wrong with his hea	st for monitoring and review tropic medications. The n also indicated that the causing the pulse-less to was nothing determined to left. A complete cardiology and for February 7, 2007.	F a w	4. A treatment plan meet was held on 2/23/07 that notuded the Director of Nursing, Director of CLS nouse manager, QMRP, parents and the individualiscuss all medications of current regimen with the and benefits. The parents pedications being dministered along with the sks and benefits. The parents of the individual control of the individual control of the informed gned off on the informed	-DC, Il to In his Irisks Is Ithe Ineir	

CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES				FORM APPROVED		
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE S		
		09G168	B. WING				
NAME OF	PROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015	02/03/2007 CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CDOSS	(X5) COMPLETION DATE	
W 331	6. The facility faile interdisciplinary terbenefits versus ris 7. In general, the facility faile oversight and esta was potential for no between the Chlora Cogentin (among the not acting quickly estimated for cardiac failured faile of the pulse-less expection of the pulse-less expection of the faile of the demonstrated faservices. 483.460(c) NURSINTHE facility must proservices in accordate the facility faservices in accordate three of the four clied of the facility of t	and to document an ami discussion of weighing the ks of the treatment plan. facility deferred decisionants, without evidence of blishment of safeguards. There egative drug interactions all Hydrate, Clozaril and he others) and the facility was enough to determine the cause bisodes and whether the RN might place the client at a low blood pressure events re. Esystemic practices results in ailure to provide health care NG SERVICES Divide clients with nursing ince with their needs. Is not met as evidenced by: Dor, interview and record ailied to ensure nursing ince with its clients' needs, for anils residing in the facility. (144) End to establish an effective establish effective establish eff		receiving adequate treatment he is also seeing a cardiologist who currently him on an event monitor to if the fainting spells are related to his heart condition (mitravalve prolapse and pulmor outflow murmur). He will follow murmur) He will follow murmur. He will follow murmur he will follow murmur. He will follow murmur he will follow murmur. He will follow murmur. He will follow murmur. He will follow monitoring is complete. 6. A treatment plan meeting was held on 2/23/07 that included the Director of CLS-D house manager, QMRP, parents and the individual to discuss all medications on current regimen with the risk and benefits. The parents were provided a list of all the medications being administered along with the risks and benefits. The paresigned off on the Informed Consent for the Use of Medications. The agenda, meeting minutes, and informed informed in the meeting have been filed #2's record. 7. The safeguards for #2 has been put in place. The parents will be documenting medication administered on the MAR and providing the record back to the home after the visit. The parents completed and had notarized the limited medical guardian form. The chloral hydrate was record.	has bee ated all yellow-len g C. to his ke ents ned om in vents er d		
			1.	discontinued as a clash aid		-	

ᇇᆘᄦ	NT OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	/UAL I	AL (1) 2		ОМЕ	NO	APPRO1 <u>0938-0</u>
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		09G168	B. Wir	NG _				
IAME OF	PROVIDER OR SUPPLIER		- '				02/0	3/2007
∰" JOH	N	•	,	Э	REET ADDRESS, CITY, STATE, ZIP CODE 1012 MILITARY RD, NW VASHINGTON, DC 20015			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	DC CBA	SS-	(XS) COMPLETIC DATE
	a. Cross-refer to W administration obset the House Manager, Fluticasone Nasal S available for treating prescribed for treating prescribed for treating addition, the client di Nasonex spray that i Manager/TME said i Nasonex spray was i b. The clients' Medic Records (MARs) and were reviewed after i administration on Jar Manager/TME was u PRN medications in i (1) Client #1's Lo needed for allergies; (2) Client #2's Tyling) every 8 hours for (3) Client #4's Ansuppository rectally as The House Manager/ had been a "tempora-	268. During the medication vation on January 30, 2007, ITME did not have pray 50 mcg (Flonase) Client #4. The Flonase was sent of allergy symptoms. In d not receive his prescribed norning. The House e mistakenly thought the PRN. Sation Administration physician's orders (POs) he morning medication away 30, 2007. The House hable to locate the following he facility that morning: Sation Administration physician's orders (POs) he morning medication away 30, 2007. The House hable to locate the following he facility that morning: Sation Suppositories, 1 are add for hemorrhoids. The said he thought this youse." Hospital discharge	W 3	1 1 1 1	team and the physician's or reflects the discontinuance. 1. The Director of Nursing ensure that all prin meds for each individual is in the homes. 2. DDS will be contacted to a referral for another dentise that is able to render the canceded by the individuals. 3. The charge nurse will ensure that result of tests are outcomes are obtained in a timely fashion. A record of examinations and procedure will be maintained in the records. 4. The Director of Nursing we ensure that all her staff is	get tre	<u></u>	31/07
i ANI	papers dated April 24, recommended the sur There was no evidence	2006 indicated they had positories for 7 days. e, however, that the original mited and/or that the PCP suppositories since		d	locumenting properly all changes on the physician's order.	4	('''	
lı e	(4) Client #1's Cor nhale 2 puffs 4 times oxpired in November 2	abivent Inhaler 15/GM daily PRN for asthma had 006. No other Combivent						,

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENT	ERS FOR MEDICARE	HAND HUMAN SERVICES				FORM	02/26/200 APPROVE
STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		NULTIPI ILDING	LE CONSTRUCTION	(X3) DATE S	
	<u> </u>	09G168	B. WII	۷G			
MAME OF	PROVIDER OR SUPPLIER		<u> </u>	<u> </u>		02/0	3/2007
97 JOI	in .		į	301	ET ADDRESS, CITY, STATE, ZIP CODE 2 MILITARY RD, NW ASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	JEMENT OF DEFICIENCIES VIUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CROSS.	(X5) COMPLETION DATE
W 331	Continued From pa	çe 31	w 3	31			
## 1	ensure that Client # addressed timely. Treflect any monitorin status of the carries November 2005, 14 3. Nursing staff faile chart timely to reflect procedures, as follow. On January 31, 2007 review of Client #1's polyps removed durit on September 7, 200 instructions said to "oplan repeat exam." // reflected the 9/7/06 c. "The assessment di instructions to call bareview of the nurse a notes failed to show usought the test result chart. At 3:02 PM, into Charge Nurse and that neither individual of the biopsies. Minureviewed Client #1's in the could not find the more than 4 months. primary care physician revealed that the clinic tests showed the polytics.	chart revealed that he had 3 ig a colonoscopy performed 6. The discharge all 9/15/06 re; biopsy and a nursing quarterly update olonoscopy and "cold biopsy d not, however, reflect the ck on 9/15/06. Further essessments and progress evidence that the facility had is for inclusion in the client's terviews with the LPN in House Manager revealed knew the outcome/findings tes later, the Charge Nurse thart and acknowledged that biopsy results documented, [Note: Interview with the in later that day by telephone is had informed him that the ps were benign.]					
	4. Nursing staff failed changes in the clients' follows:	to properly document physician's orders, as					

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES			PRINTEI FORM	D: 02/26/2007 // APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
	09G168		8. WING				
MAME OF	PROVIDER OR SUPPLIER				02/03/2007		
STJOH	IN	•	, ,	TREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015			
(X4) ID PREFIX TAG	LACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	RE CROSS	(X5) COMPLETION DATE	
W 331	Continued From pa	je 32	W 33				
TV UV	a. Clients #3 and #4 both received Metamucil 1 packet during the January 30, 2007 morning med pass. Client #2 was also administered Docusate Sodium 100 m cap (Colace). Their charts, however, reflected the following telephone order, dated 1/19/07: "discontinue Docusate, start warm prune juice by mouth 4 oz every morning followed by 4 oz water." When asked about this, the House Manager/TME and LPN Charge Nurse both stated the change would take effect February 1, 2007, as per the RN and primary care physician's instructions. They explained that this was why Clients #3 and #4's MARs still included Metamucil, and Client #2 still received Docusate. Similarly, Client #2's January 2007 POs included Certavite Liquid 480/ml, 1 T (15 ml) by mouth daily, which he received that morning. However, there was a telephone order, signed by the RN Nursing Director on 1/19/07, that said to discontinue the Certavite and begin "Berroca Plus by mouth daily." The order did not indicate whether this would be in capsule or liquid form and it did not state the correct dosage. LPN Charge Nurse looked at the aforementioned orders and acknowledged that they were not written to reflect a February 1, 2007 start date. The RN Nursing Director later confirmed that the changes were effective February 1, 2007. b. Client #2's POs from the past 12 months indicated that he was prescribed Fludrocortisone for the treatment of eczema. However, post-survey communications with the facility RN revealed that the Fludrocortisone was prescibed						

The nursing team had not identified these discrepancies prior to the survey.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/26/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 09G168 NAME OF PROVIDER OR SUPPLIER 02/03/2007 STREET ADDRESS, CITY, STATE, ZIP CODE ST JOHN 3012 MILITARY RD, NW WASHINGTON, DC 20015 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENC!) MUST BE PRECEDED BY FULL FREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE W 338 | 483,460(c)(3)(v) NURSING SERVICES W 338 Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems). This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely medical services for one of the two clients in the sample. (Client #1) 43.7 The findings include Nursing staff failed to ensure that Client #1 received dental care in a timely manner, as follows: 1. On January 31, 2007, at approximately 3:15 PM, review of Client #1's record revealed that on November 23, 2005, the dentist diagnosed large carries... need extract teeth #13, #20 and #32." The client waited 10 months before additional dental services were provided. He returned to the dentist on Septembe 27, 2006 and had one tooth (#20) extracted. 2. The client's chart did not reflect any monitoring or follow-up regarding the status of the carries found in the two teeth (#13 and #32) 14 months earlier, in November 2005. W 356 483.460(g)(2) COMPREHENSIVE DENTAL W 356 TREATMENT DDS will be contacted to get a The facility must ensure comprehensive dental referral for another dentist that treatment services that include dental care is able to render the care needed for relief of pain and infections, needed by the individuals. restoration of teeth, and maintenance of dental

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION					FORM APPROVE OMB NO. 0938-039	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	ULTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
	_	09G168	B. WIN	G	1	
IAME OF	PROVIDER OR SUPPLIER				02/0	3/2007
ST JOH	N			STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015		•
(X4) ID 'PREFIX FAG	I (EACH DEFICIENC	A'EMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LEC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	DE COMés	(XS) COMPLETIO DATE
W 356	Continued From pa	açıe 34	W 38	56		
	Based on record re	,				
XG PRE T.F	November 23, 2005 large carries need 32." The client return	2007, at approximately 3:15 t #1's record revealed that on the dentist had diagnosed" lextract teeth #13, #20 and # rried to the dentist 10 months 127, 2006 and had tooth #20				
1	or follow-up regardir	did not reflect any monitoring ig the status of the carries (#13 and #32) 14 months (2005)		!		
	he was asked on Jai whether his mouth o	at Client #1 replied "no" when a lary 31, 2007, at 4:24 PM, r teeth hurt.	W 365			
ŕ	An individual medica must be maintained	tion administration record for each client.		The parents are no longer administering medications without the MAR forms. The	- 4	
fa n	Based on staff intervi acility failed to ensur	is maintained for one of the		parents were trained on how properly document the medication administered and will turn in the Mar's to the home after the visit. A	i	
_	he finding includes:			treatment plan meeting was		

STATEME	INT OF DEFICIENCIES OF CORRECTION	F AND HUMAN SERVICES E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	T/0=		FOR	D: 02/26/26 M APPROV) 0938-03
Solitzonon		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		09G168	B. WING	3	1	
WAME OF	PROVIDER OR SUPPLIER				02/0	J3/ 20 07
ST JOH	N .			STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW		<u> </u>
(X4) ID	SUMMARY STA	A EMENT OF DEFICIENCIES	- ,	WASHINGTON, DC 20015	,	
PREFIX TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE		(X5) COMPLETIO DATE
₩ 365	Continued From pa	çe 35	W 36			DATE
	On a hi wookin be		1 000	Wine	··——	
	Client #2 to his so	i, the facility was releasing		held on 2/23/07 that include	led	
, D	, 1 1 1 2 LG 1115 DATE	ents for home visits. The reflected as blank spaces on		the Director of Nursing	1	
				Director of CLS-DC, house	, i	
				manager, QMRP, parents	-	
	eaministeled Wedic:	FROMS during the beautiful		the individual to discuss all	and	
			1	medications as hi	1	
	Attributing Of Billy Di tu	9 MARIANTIANA AJAKARA	1	medications on his current		
	= **#!!##!! * 0 . /!!	/ IDIOD/OW/ Stammer	ĺ	regimen with the risks and	1	:
		818=03611)uali6a3114		penefits. The parents were	:	į
	Areliaalion Eloi6229	1091/(18/100) (mai: max + + + + + + + + + + + + + + + + + + +		provided a list of all the		Î
	nna berenia Han lailir	IPO PORIOR PARILLES L		medications being	:	
	ecord review reveals	is. Further interviews and and no system had been		administered along with the		1
m) (6	stablished wherehv	the facility could account for		risks and however The	ir	1
	he medications Clier	t#2 received		risks and benefits. The pare	ents	- 1
are III		1		signed off on the Informed		1
1 11	should be noted that	t on January 30, 2007, at 9:		Consent for the Use of		1
1 7	~ , nan nie i lonse mi	DEPTO PERSON AND ALL TOURS		Medications.	1	Ĭ
-		TO 6 100 6 00 6 6 15 11 \$ 11	Г	the second secon		
1 ''	anne vigito gilli leaver	S IDADO With the Lieurs				4. April 1/2 1 1 1 1 1 1 1
,	'9''9''	Unc had District	!	•		
"	andery or. Zooz inter	VIOW of approvious to be a second				
		SI (JIMB P) 1000 00 00 00 00 00 00 00 00 00 00 00 0	ĺ			
H	ydrate each night (a i	ad administered Chloral				
\$	aturday and Sunday	nights). He replied "I'm not	j			
,	a a selen me unisa	Dacke the madical and	į		1	
	• 'VIIII'II'	[@ V St) Pot Afa 4 aa	1			1
,	ued been 11260 L	이 다리들은 나는 살아보니 그는 그는 그는 그는 그를 보다 없다.			1]
	AA MICH OUNDS IND IN	20019015 20027 6.4			!	· 1
	Second blice, the faci	Uty depied that that the				
11-	o arabertallin tilbut a	TIONS (A/b) Ab (A = -)				- 1
68 48	3.460(k)(1) DRUG A	pharmacy regulations. DMINISTRATION	W 368			
tha	t all drugs are ear. =:	ministration must assure stered in compliance with	i			
	anda are sow th	stered in compliance with				1

Event ID: P9G811

Facility ID: 09G168

If continuation sheet Page 36 of 42

<u>, ∵⊂!\</u>	TERS FOR MEDICARI	H AND HUMAN SERVICES			PRINTEI FORM	D: 02/26/200 // APPROVE
	AENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	COMP NC). 0938-039 [.] Survey
<u> </u>		09G168	B. WING			
NAME	OF PROVIDER OR SUPPLIER				02/0	03/2007
STJC				STREET ADDRESS, CITY, STATE, ZIP COD 3012 MILITARY RD, NW WASHINGTON, DC 20015	·Ε	
(X4) II PREFI TAG	A I GAUD DEPIGIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIA	U D DH anne	(X5) COMPLETION DATE
_ _√ W,36	8 Continued From page	ge 36	10120			<u> </u>
,	the physician's orde	IS.	W 368	8		
may Min	review, the facility fa all drugs were admir the physician's order residing in the facility					
	The findings include:					
	Manager/Trained Me presented a bottle of mcg (Flonase) and stempty. Client #4's or inhalations twice daily. The House Manager/Client #4 had received	cation pass was observed At 7:41 AM, the House dication Employee (TME) Fluticasone Nasal Spray 50 ated that the bottle was lers said to administer 2 for treatment of allergies. TME further stated that I the Flonase spray during ing med passes the day just run out.				
	MAR) revealed no doc	t a review of the client's tion Administration Record (tumentation that Flonase d at any time during the				
	Nasal Spray, 2 sprays treatment 7 AM. The had thought they were in the administered medical mornings. Review of the MAR revealed no documents.	luded Nasonex 60 mcg once daily, each nostril, House Manager/TME said PRN. He further stated that ations on most (but not all) ne client's January 2007 mentation that Nasonex on any morning during the				

<u>CENTE</u>	RS FOR MEDICARE	AND HUMAN SERVICES	- <u>-</u>		FORM): 02/26/20 1 APPROVE 1, 0938-039
STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) M A. BUI	ULTIFLE CONSTRUCTION LDING	(X3) DATE S COMPL	URVEY
		09G168	B. WIN	lG	00/0	2/200
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3012 MILITARY RD, NW		3/2007
(X4) ID	SUMMARY STA	EMENT OF DEFICIENCIES		WASHINGTON, DC 20015		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPRI	QUI DIBE CROSS.	(X5) COMPLETION DATE
W 369	483.460(k)(2) DRU	ADMINISTRATION	W 3	69		
	that all drugs, includ	administration must assure ng those that are self- ministered without error.				
	This STANDARD is Based on observation review, the facility faminasal spray was addressed in the second seco	not met as evidenced by: on, interview and record iled to ensure that prescribed inistered as prescribed, for in the sample. (Client #4)			·	
·	The finding includes					
W 386	orders (POs) afterware POs included Nason sprays once daily, ear The client had not remorning. The House interviewed immediate spray was PRN, not at that he administered not all) mornings. Re 2007 MAR revealed results afterware properties of the position	ely. He said he thought the reatment. He further stated medications on most (but view of the client's January o documentation that iministered on any morning	W 386	5		
i S F	econcile the receipt a controlled drugs in so subject to the Compre Prevention and Contro	redules if through IV (drugs 📗				

1,00

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/26/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING COMPLETED 8. WING D9G168 NAME OF PROVIDER OR SUPPLIER 02/03/2007 STREET ADDRESS, CITY, STATE, ZIP CODE ST JOHN 3012 MILITARY RD, NW WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL Ю PROVIDER'S PLAN OF CORRECTION REGULATORY OR .SC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-(X5) COMPLETION TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE W 386 ! Continued From page 38 W 386 This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification, the facility failed to maintain records of the disposition of all controlled drugs, for one of the two clients in the sample. (Client #2) The finding includes: On January 30, 2007, Client #2's physician's orders (POs) were reviewed in order to verify observations made during the morning $\sum_{i=1}^{n} (1)^{i}$ medication pass. At approximately 9:15 AM, a hand written order, dated 10/11/06, was observed that read as follows: "Chloral Hydrate 500 mg Take one table <sic> by mouth in evening as needed." The order did not indicate a purpose or use for the medication. When asked to locate it, the Trained Medicat on Employee (TME) searched through the medication (file) cabinet and a locked nurse's closet but could not locate the Chloral Hydrate (a Schedule III Drug). Review of Client #2's January 2007 Medication Administration Records (MARs) and typed POs (pharmacy) failed to show evidence that Chloral Hydrate was a current medication. The client's December 2006 POs (typed by the pharmacy) reflected the Chloral Hydrate order. There was no order, however, since then to discontinue the medication.

RM CMS-2567(02-99) Previous Versions Obsolete

At approximately 9:35 AM, a plastic bag filled with prescription medication containers (some empty, others still held medications in them) was

observed in the file cabinet. The House Manager/TME explained that the LPN Charge Nurse routinely packed Client #2's medications in the bag before his weekend visits with his parents. The House Manager/TME would then give the

Event ID: P9G811

Facility ID: 09G188

If continuation sheet Page 39 of 42

STATE	ALLY OF BEEN WEDICARI	E & MEDICAID SERVICES		<u> </u>	TURI OMBRIG	7 APPROVE 0. 0938-039
AND PL	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION	(X3) DATE	SURVEY
			A. BUILDII	NG	— COMPL	.E 1 ED
		09G168	B. WING_			
NAME	OF PROVIDER OR SUPPLIER		ST	PEET ADDRESS SITUANIA		3/2007
STJC	они		3	REET ADDRESS, CITY, STATE, 2 3012 MILITARY RD, NW NASHINGTON, DC 20015	IP CODE	
(X4) I	D SUMMARY ST.	TEMENT OF DEFICIENCIES	ID			
PREF TAG	REGULATORY OR I.	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE ACTIO REFERENCED TO THE APPR	NISHOULD BE COACA	(X5) COMPLETION DATE
W 38	36 Continued From par	ge 39	W 386			
		to the parents when they	, vv 365			
	carrie to the facility f	for their son. Inspection of the l				
ı	contents of the plas	tic bad revealed a bottle of				
* *	Higuia Chiorai Hydrai	te. The label read as follower i				
Mg	bedtime PRN for sle	ml. Take 5 ml by mouth at eep." Upon visual inspection,	İ	•.		
	the recently-assignia	d QMRP agreed that				
	approximately 45%	Of the bottle had been			·	
	TME was the QM	IRP and House Manager/	İ			
ju-	parents were docum	that time whether the lenting the administration of				
1, 11	the Chloral Hydrate.	lending the administration of	ì			
ji s						
	Interviews later with	the LPN Charge Nurse and				
μ.	the immediate-past (QMRP confirmed that the		,		
ľ	they administered du	cumenting the medications ring the weekend visits. On			ĺ	İ
(Reporte Bally or mile)	February 1, 2007, at	approximately 5:30 PM, the	1		. 1	
9 ³ f	KN Nursing Director	examined the Chloral				ſ
	Hydrate bottle and dis	etermined that approximately			,	
	cc's remaining in the	ninistered, with another 110				
	cos remaining in the	DOTTIE.	ļ			
	The survey revealed (that facility staff did not know				į
•	; when, now oπen, or ir	ו What amount the Chloral !!!				
,	i myorate was being ad	ministered. There was no	ĺ			
	the disposition of the	lity had a system to monitor			į	
i	Drug, Chloral Hydratie	Controlled Schedule III				1
e e s	It should be noted that	t the original telephone				
	order for Chioral Hydra	ate: dated 10/11/06 was for		•		
	Director confirmed that	ry 1, 2007, the RN Nursing				1
-1."	nursing progress notes	s or any other				
المورودة الراد	documentation in the r	ecord to indicate why the	1			
	Uniorai Hydrate was 😘	ent as liquid rather than				
	tablet form. At 6:05 File	M. She stated that she had				
· j	asked the LPN Charge	Nurse if he could recall				1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/26/2007

DEPA	ARTMENT OF HEALT	H AND HUMAN SERVICES			PRINTE	D: 02/26/2001
CEN	ERS FOR MEDICAR	& MEDICAID SERVICES			FORM	A APPROVED
ISTATEM	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		09G168	B. WING	3		
NAME O	F PROVIDER OR SUPPLIER		-\		02/0	3/2007
OL TZ	HN			STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	((EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	N RE COACC	(X5) COMPLETION DATE
W 38	6 Continued From pa	ge 40	14/20	0		
©[why the change from reportedly said he in pharmacy and "that survey query on the Hydrate comes in come	n tablet to liquid, and he ad faxed the order to the s what they sent us." A post-internet revealed that Chloral apsules as well as liquid form	W 38 W 39		·	
	This STANDARD is Based on observating	nove from use outdated drugs not met as evidenced by: n and interview, the facility n use, out dated medication.		All outdated medications discarded by the nurse by following the medication p and protocol for discarding medication	olicy	
	The findings include:					
	Trained Medication I to locate the following	edication pass observations, 2007, the House Manager/ imployee (TME) was asked 2 medications that were anuary 2007 physician's				
	approximately 8:35 A searched through the and could not locate the found it in a locked nullabel indicated that the expired November 20 2: The TME also four spray (Flonase). The medication had also expired times and also expired the search of the medication had also expired times and the search of the search	M, the House Manager/TME medication (file) cabinet he inhaler. At 8.41 AM, he irse's closet nearby. The medication (cartridge) had 06. Id Fluticasone 0.05% nasal label indicated the xpired in November 2006.				
	the medications had e	e labels and confirmed that				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/26/2007 FORM APPROVED

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) !	MULT	TPLE CONSTRUCTION		Q. 0938-039 SURVEY
1 2 - 12 - 12 - 12 - 12 - 12 - 12 - 12	·	IDENTIFICATION NUMBER:	A. BL				LETED
		09G168	B. WI	NG_			•
NAME OF	PROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CO 012 MILITARY RD, NW VASHINGTON, DC 20015		<u>/03/2007</u>
(X4) ID PREFIX TAG	I (EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	THE CHOCK	COMPLETION DATE
W 390	House Manager/The Charge Nurse routing the medicine cabina added "We don't us pointing to the nurs." It should be noted to documented having medication supplies.	IE stated that the facility's nely checked medications in at and the closet. He then anything over there" while a's closet. The pharmacist inspected the facility's	W	890			

7-7-76	•						03/06/2007 APPROVED		
Health F	legulation Administra	arion							
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDIN		(X3) DATE SU COMPLE			
		09G16B		B. WING_		02/0	3/2007		
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	STREET AD	DRESS, CITY,	STATE, ZIP CODE				
AHOL TZ	Í			LITARY RD, NW IGTON, DC 20015					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SCIDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) D				
1 000	INITIAL COMMEN	TS		1000					
in in the same	30, 2007 through F sample of two resid	was conducted from ebruary 3, 2007. A r lents was selected fr of four men with var les.	andom om a						
MATTER STATES	observations at the program, interviews and residential staff	survey were based of group home and one with residents, day fand the review of cords, including incider	e day program linical and						
1 044	3502.3 MEAL SER	VICE / DINING AREA	AS	1 044					
	All food and drink s from spoilage, and	itall be clean, wholes properly prepared.	some, free		All staff will be trained by nutritionist on how to prop	erly			
	Facility staff failed t Resident #2's foods	inet as evidenced by a consistently prepar s in accordance with exture (pureed), as f	e his		prepare pureed foods. The training will be quarterly/a needed to ensure all staff an adequate understanding pureed meals. The training	s has ig of			
	30, 2007, beginning Resident #2's hash ground texture. He scrambled eggs, sta and a can of Ensure At 7:33 AM, the res	eal was observed or at approximately 7:5 prowns were prepan was also served lunt andard cream of whe Plus nutritional sup- ident coughed while a prompted staff to in	30 AM, ed to a apy eat cereal plement, eating the		will also include the dysph and what it means in rega to individuals who suffer fr aspiration.	rds	The second of th		
Health Regul	January 30, 2007, b 55 PM. Resident #2 into bite-sized piece	was observed later of the segment of an approximation of the segment of grant and a side serving ach and a side serving of the	nately 5: agna (cut arlic						

erina. National

STATE FORM POGET

If continuation sheet 1 of 21

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		(3) DATE SU COMPLE	JRVEY TED
·		09G168	B. WING			
NAME OF I	PROMDER OR SUPPLIER	STRE	ET ADDRESS, CIT	Y, STATE, ZIP CODE	02/03	3/2007
ST JOHI	N	3012	MILITARY RD HINGTON, DC	. NW		
(X4) ID PREFIX TAG	I LEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFI	00000	(XS) COMPLE DATE
1044	Continued From pa	ge 1	1044			
	3. On January 31, 2 was served a luni	2007, at 12:19 PM, Resider ch that had been pureed.	1 <i>t #</i>			,
£,-	On January 31, 200 Mahager and the Li	7, at 12:50 PM, the House				
	diet -for several mo chart confirmed that	esement. They both stated to been prescribed a pureed of the clients the resident's foods were to be per physician's orders (5/1)				
' . i		MS AND BATHROOMS	1074	St. John's has ensured that a		
f	cach bedroom shall following items for ea	be equipped with at least thack resident:	e l	And the second of the second o	- In (1 (Donne) Staffpale	. 10 2. Qualitati inter (g. 1 . <u> </u>
(c) Drawer space; an	d		dresser was provided for #2 to place his clothing items.	i	:
	This Statute is not no The GHMRP failed to ad his own drawer s inderclothes, as folk	ensure that Resident #2		A COLUMN TO THE PARTY OF THE PA	<u> </u>	er vanes i i
1 pl in ex ac	and #2 revealed that and #2 revealed that and socks astic bag in the closs dicated that this was epilaining that there we commodate another	at approximately 5:20 PM, room shared by Residents # t Resident #2's supply of were being stored in a et. The House Manager routine, standard practice, was insufficient space to r dresser in the bedroom. was in the room was being at #1.	<u> </u>			
i i	6, SMOONS (503.5 BEDROOMS)	ND BATHROOMS	1077	A storage bin was purchased	-	

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA 制度 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G168 NAME OF PROVIDER OR SUPPLIER 02/03/2007 STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW ST JOHN WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX (X5) REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE 1077 Continued From page 2 1077 space for each resident's seasonal, personal clothing and personal effects. This Statute is not met as evidenced by: Resident #2's bedroom did not provide sufficient storage space to accommodate his personal clothing. See 1077 1 090 3504.1 HOUSEKEEPING 1090 The interior and exterior of each GHMRP shall be A contractor has been 3/10/07 maintained in a safe, clean, orderly, attractive, contacted to make the and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable necessary repairs needed to the side walk. The work will odors. begin on Saturday, March 10, 2007 This Statute is not riet as evidenced by: Exterior: On January 30, 2007, at approximately 6:10 AM, The same contractor will clean two sections of concrete on the front walkway and make the necessary were broken and in disrepair. One broken repairs to the carpet. section (hole), meas uring approximately 5 inches by 9 inches, had a criunk of original concrete loosely sitting in the hole. This was situated in the center of the walkway and presented a

Dining room:

On January 30, 2007 at approximately 6:30 AM. a 7-inch tear was observed in the dining room carpet, just inside the door leading to the deck outside. The torn carpet remained in that condition throughout the remainder of the survey.

potential trip hazard. Next to the front walkway was a rusted can of paint. The rusted can and broken concrete remained in that condition throughout the remainder of the survey.

ுர் இதையிation Administration

母語 FORM

Health Requiation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G168 02/03/2007 MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW ST JOHN WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS. REGULATORY OR LISC IDENTIFYING INFORMATION) COMPLETE TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE 1180 Continued From page 3 1180 1. The Incident Management I 180 3508.1 ADMINISTRATIVE SUPPORT Coordinator/QA will provide L180 training to all staff and nurses Each GHMRP shall provide adequate on incidents and incident administrative support to efficiently meet the reporting. needs of the residents as required by their Habilitation plans. Hara. TENN O 2. A treatment plan meeting This Statute is not met as evidenced by: was held on 2/23/07 that 1. The GHMRP failed to provide sufficient administrative oversight to ensure that internal included the Director of 1161 policies on the reporting and investigation of Nursing, Director of CLS-DC. incidents, including allegations of abuse, were 3. house manager, QMRP. implemented. parents and the individual to See 1379 Also see Federal Deficiency Report - Citations W discuss all medications on his 104, W149, W153 and W154 current regimen with the risks and benefits. The parents 2. The GHMRP failed to establish and implement were provided a list of all the a system of documenting a thorough review of residents' treatment plans and options, to include medications being clear explanation of potential risks and benefits of administered along with their proposed medication regimens with the resident's risks and benefits. The parents legally authorized healthcare decision-maker. signed off on the Informed See 1500.3 Also see Federal Deficiency Report - Citations W Consent for the Use of 104, W124, W128, W263 and W285 Medications. There was no system established to document Resident #2s behaviors and the administration of The parents are no longer. medications during weekend visits with his administering medications parents. without the MAR forms. The See 1474,1/,2 parents were trained on how to Also see Federal Deficiency Report - Citations W 104, W111, W128, V/365 and W386 properly document the medication administered and 4. The survey revealed inadequate supervision of the nursing staff. will turn in the Mar's to the See 1292, 1401, 1474, 1484 home after the visit. Also see Federal Deficiency Report - Citations W 104, W331, W365 and W368 4. The Director of Nursing ுள்ள Regulation Administration PORM. takes full responsibility in ensuring that adequate supervision of the charge nurses is in place.

₩D PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER, IDENTIFICATION NUMBER 09G168	/ĈLIA BER:	(X2) MU A, BUIL(B, WINC		. Co	ATE SURVEY DMPLETED 02/03/2007	
NAME OF F	PROVIDER OR SUPPLIER		3012 MILIT	ADDRESS, CITY, STATE, ZIP CODE MILITARY RD, NW INGTON, DC 20015				
(X4) ID PREFIX TAG	(EACH DEFICIENC')	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S (EACH DEFICIENC'/ MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE PREFIX REFERENCED TO THE				10ULD BE CRO	SS- COMP	
S. L. S. S. S. S. S. S. S. S. S. S. S. S. S.	Each GHMRP shall that shows the follow (c) The categories is and direct care staff. This Statute is not an On January 30, 2000 Organizational Chart revealed that the box staff did not distinguinumbers of support was stated that the prevised, however, no presented before the	and numbers of support; and The tas evidenced by: The tas evide	chart tive 06, lome" f. It	186	The Director of DC-CL ensure that each home organizational chart to reference too. The chainclude categories and of supportive and direct staff for each home.	e has an art will number	4/1/07	
	Each GHMRP shall have an organization chart that shows the following: (d) The lines of authority. This Statute is not met as evidenced by: Driganizational Chart, dated December 2006, evealed that the chart did not reflect lines of authority of staff within the GHMRP, and within the nursing department. It was stated that the chart was being further revised, however, no dditional information was presented before the urvey ended.		nart	187	The Director of DC-CLS ensure that each home organizational chart that reflects the authority of swithin the home and the nursing department.	has an	4/1/07	
E: de re	esponsibilities and du		najor ontrol	1	All personnel records we updated to reflect the coljob description for all St. John's employees.	ere ;	3/1/07	
FORM	on Administration		0890	PS	OG811	If continu	ation sheet 5 of	

Health	Regulation Administr	ation				FORM	APPROVE	
STATEMI AND PLA	ENT OF DÉFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM 09G168	R/CLIA MBER:	(X2) MU A. BUILL B. WING		(X3) DATE S COMPLI	ETED .	
NAME OF	PROVIDER OR SUPPLIER	030.00	STREET AD	DRESS CIT	Y, STATE, ZIP CODE	02/0	3/2007	
STUD	IN		3012 MILI	MILITARY RD, NW HINGTON, DC 20015				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	F ()) (ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	-22090 38 C	(X5) COMPLETE DATE	
1 202	Continued From pa	ge 5		1202				
206	Review of personner revealed no evident for the following: - the House Manage His file included a jo	POLICIES r to employment and thall provide a physicial alth inventory has been employee is health.	y 3, 2007 riptions Leader. evious ialist)	I 206	All personnel records have current health certificates the indicated that they are heal and capable of completing their assigned duties.	nat		
	This Statute is not m Review of personnel i	et as evidenced by:	0.007					
	revealed no evidence certification/inventory	of a current health	3, ZUU/			·	<u></u>	
	- 1 of the 10 direct sup	oport staff (FN), and			Most training is completed annually or as needed. The	re		
i i m	- the recently-hired Cif				is a training schedule completed by the homes an			
1223	3510.4 STAFF TRAIN	ING	[]	223	are maintained by the Direct			
	Each training program	agenda and record of	of staff	1	of DC-CLS and is posted in			

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G168 02/03/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW ST JOHN WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) PRÉFIX (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE 1 223 Continued From page 6 1 223 participation shall be maintained in the GHMRP and available for review by regulatory agencies. This Statute is not met as evidenced by: On February 3, 2007, review of staff training records revealed no agendas for recent trainings, including: - Pureed Diets/dysphagia (6/21/06) - Seizures/Infection Control (7/26/06) and - Aspiration/Infection Control (12/18/06) 1 227 3510.5(d) STAFF TRAINING 1227 Each training program shall include, but not be Infection control is reviewed limited to, the following: On monthly with all staff in the going (c) Infection control for staff and residents; monthly house meetings. This is done by the nurse and This Statute is not met as evidenced by: reiterated by the QMRP. On February 3, 2007, review of staff training records revealed no evidence that staff had received ongoing training (in 2005, 2006 or thus far in 2007) on the CHMRP's disaster plans, | 228 | 3510.5(e) STAFF TF:AINING 1228 Each training program shall include, but not be The residents of the homes 2/07 limited to, the following: have self direction meetings (e) Resident 's rights; weekly. The review of the resident's rights is on the This Statute is not met as evidenced by: agenda for the meeting. This On February 3, 2007, review of staff training is done to ensure that all records revealed no evidence that staff had received ongoing training (in 2005, 2006 or thus individuals are aware of their far in 2007) on resident rights. rights.

HEND PL	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/SIDENTIFICATION NUMB	ER/CLIA IMBER: A. BUILDING B. WING			(X3) DATE : COMPL	.ETED
ST JO	PF PROVIDER OR SUPPLIER	3	TREET ADDR 3012 MILITA VASHINGTO	ARY RE	TY, STATE, ZIP CODE D, NW 5 20015	<u> UZ/I</u>	<u> </u>
(X4) IC PREFIX TAG	X (EAGH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIC	LL DN)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD ! REFERENCED TO THE APPROPRIATE D	SE CDOCC	COMP DA
122	(f) Specialty areas reresidents to be served to, behavior manager recreation, total contechnologies; This Statute is not in On February 3, 2007	am shall include, but no ing: elated to the GHMRP a sed including, but not limement, sexuality, nutrition amunications, and assistant as evidenced by: // review of staff training	ot be	229	Staff members training is no limited to the needs of the individuals in the home but a individuals that St. John's serve.		
1 232	received ongoing traifar in 2007) on huma communication. 3510.5(i) STAFF TRAE Each training program	ท shall include, but not ig:	thus or 12 be	32		·	,
and del	This Statute is not me On February 3, 2007, records revealed no e received ongoing train	et as evidenced by: review of staff training widence that staff had ning (in 2005, 2006 or th ng and training resident	nus				
	made available at all ti review by personnel of agencies.	ept in a centralized file mes for inspection and	and 126	1	All personnel records are maintained at the main office for security purposes. They are made readily available to those who are authorized to review them.	On- goin	g
的 新 egula 的 那ORM 。。。。	ation Administration 1		ОЛИВ	Pý	9G811	continuation s	sheet 8 or

AND STEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING_ 09G168 02/03/2007 MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW ST JOHN WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PRÉFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REGULATORY OR I.SC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG 1261 Continued From page 8 1261 This Statute is not met as evidenced by: On January 30, 2007, a request was made to access personnel records for all staff employed by the GHMRP. Review of the personnel records on February 3, 2007 revealed no records 海田田民 available for the nursing staff (LPN Charge 包门基本实 Nurse, Registered Nurse, Nursing Director). No additional information was received since then, 3513.1(b) ADMINISTRATIVE RECORDS 1271 Each GHMRP shall maintain for each authorized agency 's inspection, at any time, the following administrative records: (b) Personnel records for all staff including job All personnel records are Ondescriptions either at the GHMRP or in a central maintained at the main office office and made available upon request; going for security purposes. They are made readily available to This Statute is not met as evidenced by: On January 30, 2007, a request was made to those who are authorized to access personnel records for all staff employed review them. by the GHMRP. Review of the personnel records on February 3, 2007 revealed no records available for the nursing staff (LPN Charge Nurse, Registered Nurse, Nursing Director). No additional information was received since then. 3514.3 RESIDENT FECORDS 1292 Each record shall include, but not be limited to, St. John's maintain the the requirements of D.C. Law 2-137, D.C. Code § Onresidents records electronically 6-1972 (1989 Repl. Vol.). going and paper-based. There is This Statute is not met as evidenced by: also a duplicate copy of the 1. D.C. Law 2-137, Section 6-1972 paper-based record "Complete records for each customer shall be maintained at the main office. maintained and shall be readily available to

<u>Health</u>	Regulation Administr	ation				FORM	APPROVED
TATEMEI	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 09G168	ER/CLIA UMBER:	(X2) MULTA. BUILDI B. WING	TIPLE CONSTRUCTION	(X3) DATE S COMPL	ETED
2 NAME OF L	PROVIDER OR SUPPLIER	V3010 0	CTREET AS	DDEGO AUTY		02/0	3/2007
HOLTS			3012 MIL	ITARY RD.	STATE, ZIP CODE		
2-778-14 ₁	, ,		l	STON, DC 2	(0015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	I SHOULD BE CROSS.	(X5) COMPLETE DATE
1292	Continued From pa	ge 9		1 292			
	who are directly inv; include: (5) A record of each	and immunizations." ant #1's record and in HMRP failed to obtain erformed on tissues ing a 9/7/06 colonose ficiency Report - Cita ant #2's record reveate dated 7/5/06 indicated in the resident's so not describe in detained the resident two scribing what was obty clinic IND. The resident two scribing what was obty clinic IND. The resident whose no drainage aver, whether the clinic the clinic. When the clinic. When the nurse said the an abscess. Momentad been a pressure stresident's record fail	on which Interviews In the Interviews In the Interviews In the Interviews In the Interviews In the Interviews In the Interviews In the Interviews Intervi				
	what, if any, treatmer weeks that followed. Also see Federal Def 153.12 and W154.2		ļ				
	2. D.C. Law 2-137, S Complete records fo	ection 6-1972 • each customer sha	ll be				

Health	Regulation Administr	ation				FORM	APPROVE
STATEME AND PLAI	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIE	ER/CLIA IMBER;	(X2) MULTIPLE CONSTRUCTION R; A. BUILDING B. WING			SURVEY ETED
NAME OF	PROVIDER OR SUPPLIER	09G168	OTOLET AT	NOTIFICA OUT		02/0	3/2007
STJOH			3012 MIL	JUNESS, CITARY RD. GTON, DC	Y, STATE, ZIP CODE , NW 20015		
(%4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CROSS.	(X5) COMPLETE DATE
I 292	maintained and sha professional persor who are directly inv- include: (8) A medication his	Il be readily available s and to the staff wo blved These record tory and status"	rkers Is shall	1 292			
ST PR	Resident #2 was ad during home visits v every other weeken the GHMRP did not	rd review indicated the ministered medication with his parents, approximately. The survey reveal have a record of the hinistered during the ficiency Report - Cital 36	ons oximately led that status of home			,	
1379	3519.10 EMERGEN	CIES		1 379			
	In addition to the repeach GHMRP shall realth, Health Facility unusual incident or einterferes with a resignarrangement, well be places the resident a be made by telephor followed up by writter four (24) hours or the	notify the Department ties Division of any of vent which substanti dent's health, welfar sing or in any other w t risk. Such notification e immediately and signotification	t of ther ally e, living ay on shall hall be		The Incident Management Coordinator/QA will provide training to all staff and nurse on incidents and incident reporting as required by DC regulation (22 DC Chapter 3 Section 3519.10).	28	1/07
78	This Statute is not m Review of incident re- emergency room (EF: significant incidents to Department of Health	ports revealed 9 hos i) visits and 3 other nat were not reported		ŧ			
;	 An incident report of Resident #1 was taked ER) after complaining 	л to an emergency re	oom (

PRINTED: 03/06/2007 FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER; COMPLETED A. BUILDING B, WING_ 09G168 02/03/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD. NW NHOL TO WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-COMPLETE TAG REGULATORY OR LISC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG Continued From page 11 1379 The hospital diagnosis was pneumonia. 2. An incident report dated 8/31/06 indicated that Resident #1 was taken to an ER at 4:00 PM after he "was having elevated breathing." 3. An incident report dated 9/15/06 indicated that Resident #1 was tallen from his day program to an ER via ambulance at 9:30 AM after he"was having difficulty breathing." 4. An incident report dated 2/23/06 indicated that 911 was called because Resident #2 was not well . At approximately 7:00 AM, he did not get out of bed for breakfast and his medications. The incident reportedly occurred at 11:45 AM; however, the report was not clear as to what constituted the "incicent," It should be noted that the client's parents took him to the hospital on 2/ 21/06 where he was diagnosed with pneumonia. The Charge Nurse, QMRP and parents were notified on 2/23/06. There was no evidence that DOH received notification of either incident 5. An incident report dated 3/3/06 indicated that Resident #2 was taken to a hospital after being weak and unable to talk or eat independently. He was again diagnosed with pneumonia. 6. An incident report dated 3/9/06 indicated that 911 was called at 8:30 AM after Resident #2 displayed prolonged and intense behavioral episodes. Staff described him as "agitated, jumping up and dowr ... running around the house ... taking off his clothes." The client reportedly

the ER via ambulance.

sustained a cut to the left foot and was taken to

7. An incident report dated 9/6/06 indicated that 911 was called and Resident #2 was taken to the

-7	Regulation Administr	ation	<u> </u>			ORIVI	APPROV
STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI 09G168	R/CLIA MBER;	(X2) MUI A. BUILD B. WING		(X3) DATE S COMPLE	ETED
NAME OF	PROVIDER OR SUPPLIER	030100	STREET ADD	DRESS CITY	STATE, ZIP CODE	02/0	3/2007
ST JOH			3012 MILI WASHING	TARY RD.	NW .		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY BC IDENTIFYING INFORMA	FDU	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SI REFERENCED TO THE APPROP	HÖULD BE CROSS	(X5) COMPLET DATE
1391 3 F	consciousness." The hypotensive (cause indicated) and dehy 8. An incident reported taken to the ER by a consciousness." It is from the breakfast the hospital again determine hypotensive (cause) 9. An incident reported that staff observed of swelling on the left of incident report further face" and "Emergence" and "	tt 8:40 AM after he "we hospital determine of the low blood presentated." It dated 9/29/06 indicated and Resident embulance after he "le appened after he go able and began walkinined that he was not indicated) and defined that he was not indicated a "cut" on any Inpatient Hospitalization of versident Hosp	ated that #2 was ost t up ng. The hydrated atch and he the "cation." ated of every		Current licensures were obtained from the clinicianave on file at the main c	ans to	07
n n p	idividual habilitation ecessary by the intel rofessional services	poals and objectives oplan, as determined to disciplinary team. The may include, but not see provided by indivi	o be e be		G811	If continuation sh	

<u> </u>	Requiation Administr	<u> tion</u>			<u> </u>		
Idekatemei Topplan	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI 09G168		(X2) MUI A. BUILD B. WING		(X3) DATE S COMPL	ETED
NAME OF I	PROVIDER OR SUPPLIER	096166	STOCETA	DDBECS OUT	STATE, ZIP CODE	02/0	3/2007
STJOH			3012 MI	LITARY RD, IGTON, DC	NW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY CONTROL OF THE SECTION OF THE SECTION OF THE SECTION OF THE SECTION OF THE SECTION OF THE SECTION OF THE SECTION OF THE SECTION OF THE SECTION OF THE SECTION OF THE SECTION OF T	FULL	PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SHOI REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETE DATE
1391	trained, qualified, at District of Columbia disciplines or areas (a) Medicine; This Statute is not a Review of personner revealed that the Gievidence of current professional service—physical therapist (-psychiatrist (exp. 1)	r d licensed as require law in the following of services: rnet as evidenced by: records on Februar-IMRP failed to maint licenses for the following providers:	y 3, 2007 ain wing	1 391			
	exp. 12/31/06) 3520.3 PROFESSIO PROVISIONS Professional service and evaluation, includevelopmental levels services, and services deterioration or furth resident. This Statute is not in The GHMRP failed to services to prevent direction, and including accordance with his pataff failed to maintail facility.	s shall include both diding identification of and needs, treatmes designed to preveier loss of function by et as evidenced by: provide nursing and eterioration or furthes follows:	ERAL liagnosis nt nt the dental r loss of e Nasal	I 401	The Director of Nursing ensure that the charge n have all prescribed PRN medication on site for the individuals in the home.	urse	30/07

aHth Regulation Administration ATE FORM lealth Regulation Administration 学術MATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 09G168 02/03/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3012 MILITARY RD, NW NHOL TE WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE TAG TAG 1401 1401 Continued From page 14 368 Nursing staff failed to keep PRN ("as needed") medications available in the facility for residents' needs. For example, the trained medication 10 m employee was unable to locate the following i de medications on January 30, 2007; ANTER a. Resident #1's Loratadine D-24 MAMS b. Resident #2's Tylenol 325 mg E. (c. Resident #4's Anusol suppositories, and $\{i\}_{i=1}^{n}$ d. Resident #1's Combivent Inhaler 15/GM (for asthma). Also see Federal Deficiency Report - Citation W 331 3. Review of Resident #1's record revealed that on 11/23/05, a dentist found cavities in three of his teeth (#13, #20 and #32); the dentist recommended extracting all three. The resident 13 Y L waited 10 months (9/27/06) before one tooth (#20 **第**次数据运输) was extracted. Fourteen (14) months passed prosince the 11/23/05 discovery of carries and the other two teeth (#13 and #32) had not received treatment. Interviews with nursing staff and $\mathcal{L}(\{(2,2,3)\})^{\prime\prime}$ further record review failed to show evidence that the nursing staff had detected the unmet need, 1prior to the survey. 4. Interviews and record review revealed that nursing staff failed to obtain the results of diagnostic tests - biopsies of polyps removed from Resident #1's colon on 9/7/06. Also see Federal Deliciency Report - Citation W

Health I	Regulation Administra	tion				FORIV	TAPPROVE	.L
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUMBER DEG168	R/ČLIA IBER:	(X2) MUL A. BUILD B. WING	ing	(X3) DATE S	ETED	_
NAME OF I	PROVIDER OR SUPPLIER	090100	STREET AD	INDESS CITY	STATE, ZIP CODE	02/0	03/2007	_
ат Јон			3012 MIL	ITARY RD, STON, DC	NW		·	
((4) ID PREFIX TAG	(EACH DEFICIENCY	"EMENT OF DEFICIENCIES MUST BE PRECEDED BY F C IDENTIFYING INFORMA	FULL	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEI	CROSS-	(X5) COMPLETE DATE	_
l 422	Continued From pa	ge 15		1 422				_
1422	3521.3 HABILITATI	ON AND TRAINING		I 422				
NAME ST J	and assistance to rethe resident 's Indiv This Statute is not an analysis of the Individual of the Individual of the Individual of the Individual of the Individual of the Individual of the Individual of the Individual of the Individual of the Individual of Individual	provide habilitation, to esidents in accordance dual Habilitation Planmet as evidenced by: 2007, Resident #2 was re of a ground texturings. At dinner that evidence that the resident had that the resident had existed placed that the resident had existed prepare Reside with his physician's control of the province of th	e with s served e and ening, bieces, a bieces. had been acility nt #2's		All staff will be trained by the nutritionist on how to properly prepare pureed foods. This training will be quarterly/as needed to ensure all staff has an adequate understanding o pureed meals. The training will also include the dysphagiand what it means in regards to individuals who suffer from aspiration.	, f	1/07	
\$24.00 \$4.474	receive Fluticasone accordance with his Review of the reside administration record blank spaces for the evidence that the residence that the residence allergies all month Also see Federal De 368 and W369 3522.5 MEDICATION Each GHMRP shall redication administration resident. This Statute is not many the statute of the parameters of the parameters of the statute of the parameters of the	d for January 2007 she Flonase spray, with resident received the treet. ficiency Report - Citates AS maintain an individual atton record for each	eleasing	l 474	1. The parents are no longe administering medications without the MAR forms. The parents were trained on how properly document the medication administered and will turn in the Mar's to the home after the visit. A treatment plan meeting was held on 2/23/07 that included the Director of Nursing, Director of CLS-DC, house manager, QMRP, parents and the individual to discuss all	to	/23/07	

Health F	Regulation Administr	ation				, 01/1/11	ATTROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM		(X2) MUL A. BUILDI B. WING		(X3) DATE SI COMPLE	ETED
may.	<u> </u>	09G168	·			02/0	3/2007
NAME OF P	ROVIDER OR SUPPLIER				, STATÉ, ZIP CODE		
HOL TE	·		3012 MILI WASHING	TARY RD, TON, DC			<u></u>
(X4) ID 유포류FIX TAG	(EACH DEFICIENCY	NIEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETE DATE
\$7 100 100 100 100 100 100 100 100 100 10	his monthly Medica MARs). Staff thougadministered medic but were not docum amounts of any of the January 31, 20, 7:51 AM, the immedication Profess the parents had refided document medication record review revealestablished whereby the medications Referred to January 30, 20, 20, 20, 20, 20, 20, 20, 20, 20, 2	at on Administration Reght that his parents cations during the homenting the date, time he medications admin 07 interview, at approduced ate-past Qualified Medical (QMRP) indicated as Further interview and no system had beythe facility could access dent #2 received. 2007, review of Resid POs) revealed a hand of the Trained Medication containers (seed medications in the cabinet. Inspection of the bag revealed a bottle bag revealed a bottle library interviews and record staff did not know who unt the Chloral Hydrount the Chloral Hydrount the Chloral Hydrount interviews and evided stem to monitor the dishedule III Drug, Chloral Hydrount	ne visits of nistered. eximately lental led that to vs and een count for ent #2's il written vs: " ssic> by ked to dication e Chloral bag filled some the the of ction, il review hen, how ate was noe that sposition al	1474	medications on his current regimen with the risks and benefits. The parents were provided a list of all the medications being administered along with the risks and benefits. The passigned off on the Informed Consent for the Use of 2. Medications. 2. All controlled drugs are locked under double locks. The medication is counted before administration to ensure remaining is concumited the record. Only the nurses and TME's administration. The chloral hydrate was never used at group home. Chloral hydrate was discontinued on 2/5/0. 3. The Director of Nursing ensure that the charge nur have all prescribed PRN medication on site for the individuals in the home.	e neir nents i trent the ate 7. will	
	on January 30, 2007	dication pass was obs 7. At 7:41 AM, the Ho edication Employee (use				

<u>Health f</u>	Regulation Administra	stion					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	(X2) MUL- A. BUILDI B. WING	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
NAME OF	TO OVER OR CHARLES	V3G108	CTREET AR	DDESS CITY	STATE TIP CODE	02/0	3/2007
ST JOH	PROVIDER OR SUPPLIER		3012 MIL	TARY RD, STON, DC			,
(X4) ID FREFIX TAG	(EACH DEFICIENCY	N'EMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SHOIL REFERENCED TO THE APPROPRIA	LLD BE CROSS-	(X5) COMPLETE DATE
474	presented a bottle of mcg (Flonase) and empty. Resident #4 inhalations twice da The House Manage Resident #4 had reduring the morning day before; however January 2007 MAR	igle 17 of Fluticasone Nasal stated that the bottle 4's orders said to adrally for treatment of all of the fluther stated caived the Flohase's and evening med pater review of the residulevealed no docume and administered at a	was ninister 2 llergies that pray sses the ent's entation	474			
1 484	medication that is d or has reached the worn, illegible, or m. This Statute is not inspection of the me	promptly destroy pre iscontinued by the phexpiration date, or ha issing label. In et as evidenced by edication supplies on	nysician as a	1484	All discontinued and out medications have been discarded by the nurse been on the governing polices procedures. The nurse walso ensure that the labe	pased and vill	
	Inhaler, prescribed '	he following: a vailable of Combive as needed" for Resideration date of Noven	dent#1's		legible and list the prope administration for the medication.	l	
	Flonase) had a disc date.	ulicasone 0.05% nas ald after November 2 ciency. See Federal ated 2/25/05.	2006				
1 500	3523.1 RESIDENT'S	•		I 500			

THE TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB 09G168			(X2) MULT A. BUILDII B. WING		(X3) DATE SURVEY COMPLETED 02/03/200		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE	<u> </u>	, <u> </u>
ST JOH	N			TARY RD, STON, DC 2			
(X4) ID PREFIX TAG	(EACH DĒFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC (DENTIFYING INFORM)	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	DULD BE CROS	
I 500	chapter, and other laws.	dance with D.C. Law applicable District ar	nd federal	1 500	All staff will be trained the nutritionist on how properly prepare pureed. This training will be quarterly/as needed to	to d foods.	3/30/07
A A A	1. The GHMRP far Resident #2 to recomis specially-preson D.C. Law 2-137, Someone in the diet, and where or nutritionist, to a special process of garding the was given lassed whole slice of garding the staff failed to consider the staff failed to consider in the staff failed to consider	ection 6-1965(f) as the right to a nourit dered by a physician :	ht of ance with shing and/or served ure and evening, pieces, a pieces. thad been Facility dent #2's		all staff has an adequate understanding of pureed meals. The training will include the dysphagia at what it means in regard individuals who suffer fraspiration.	d I also and Is to	
	See 1044 2. The GHMRP fareceived dental se D.C. Law 2-137, S "Each customer stadequate medical ailments" Review of Resider 11/23/05, a dentist teeth (#13, #20 and dentist recommen The resident waite #20) was extracted.		ompt and sical discontinuous that on the teeth. one tooth (2/3/07, the		2. DDS will be contacte a referral for another de that is able to render the needed by the individual	entist e care	3/25/07

Health I	Regulation Administr	ation		<u> </u>		, 0	AND AFFRO	<i>/</i> C L
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MUL A. BUILDI B. WING		co	TE SURVEY MPLETED	•
ELAME AE	BROWNER OR OWNER	09G168	070557 4 5	20520.05			02/03/2007	
ST JOH	PROVIDER OR SUPPLIER N		3012 MILI	TARY RD, STON, DC	, SȚATE, ZIP CODE NW 20015			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SCIDENTIFYING INFORMAT	TULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CROS	(X5) SS- COMPLE CY) DATE	
1500 1500 1500 1500 1500 1500 1500 1500	treatment and there staff had monitored 3. The GHMRP fai #1's legally-authoriz decision-makers (hi explanation of the passociated with the regimen, to include the parents. D.C. Law 2-137, Se "All customers have unnecessary or excurred the date, time or ammedications administ prescribed in October equest, as a sleep visits. The facility has that his parents, who surrogate healthcare received a full review the medications and for drug interactions document an interdirection of the date, in the direction of the medications and for drug interactions and for drug interactions bet Clozaril and Cogenti was taking. The fac	e was no evidence that I the resident's dental is the resident's dental is led to document that Fixed surrogate health crisis parents) received a potential risks and beninsident's medication securing written conscipling written conscipling written conscipling written conscipling written conscipling written conscipling written documents of any of the stered. Chloral Hydral et 2006, at his parent's aid for use during the act no documented evidence served as his designed be decision-makers, has worthe risks associated the facility failed to sciplinary team discussions.	Resident are full efits ent from a cations enting te was shome dence eated dence eated dence eated dence eated dence eated ed with potential sion of gative rate, ns he	1500	3. At the treatment plan meeting on 2/23/07 the parents of #2 was provided limited guardianship paperwork. The parents provided the signed notaris guardianship paperwork of 3/6/07 for #2. It has been placed in the medical and book. The parents were provided a list of all the medications being administered along with the risks and benefits. The parsigned off on the Informed Consent for the Use of Medications. 4. At the treatment team meeting on 2/23/07. It was explained to the parents the is St. John's responsible for ensuring that #2's monies in protected and safeguarded And as his residential provided bases to ensure the same and the safeguarded and safeguarde	zed n ISP eir ents ents ider	2/23/07 3/6/07	
	124, W263 and W28 It should be noted th ambulance to the em	ficiency Report - Citati	ken by		we have to account for all he monies. The family was as to provide receipts of how to money was spent to place his financial record. The parents provided the receipts	ked the in		

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/03/2007			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
©T JOHN				TARY RD, N TON, DC 20			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CI (EACH CORRECTIVE ACTION SI REFERENCED TO THE APPROPI	HOULD BE CROSS-	(X5) COMPLETE DATE
1 500	Chloral Hydrate PF risk, including acut and/or cardiac failu	o cetermine whether to RN might place the re ellow blood pressure tre. Inoted that this is a nederal Deficiency Rep	esident at events epeat	1 500			
	Resident #2's pers accordance with the interdisciplinary teal large payment duri action settlement, under the direction developed a list of resident. According was sent from the to Resident #2's perspend \$2,049.53 (abehalf, and "in according supplied at the QMRP revision of the personal set with the QMRP revision of the personal set of the pers	iled to show evidence onal funds were spere plan set forth by them. Resident #2 record 2005 as part of a The interdisciplinary of the D.C. Superior items that would beng to a letter dated 12 GHMRP's Residential arents, the parents we check #133) on their ordance with the item he Court hearing." Invested that the parent to verify how their so er interview revealed the ther or not they put on the list originally ence that the GHMR pursued the matternos of the check to hear of the check to	nt in e eived a class team, Court, nefit the l/1/05 that al Director ere to son's nized nterview ts had not in's funds archased a prepared. P or its in the year				
	parents were recog care decision-mak	that although Reside gnized as his designa ers, there was no eve ed by a court to serve al guardian.	ated health idence that				